April, 1957

MENTAL HYGIENE

Published Quarterly by the
National Association for Mental Health

Quarterly Journal of the

National Association for Mental Health, Inc.

George S. Stevenson, M.D., *Editor*
Harriett Scantland Hoptner, *Assistant Editor*

MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials and students of social problems find it of special value.

$6.00 a year (Canadian $6.25; foreign $6.50). Single copy $1.50. Publication office: 374 Broadway, Albany 7, N. Y. Editorial and business office: 10 Columbus Circle, New York 19, N. Y. Second class mail privileges authorized at Albany, N. Y.

VOLUME FORTY-ONE, NUMBER TWO *April, 1957*

Articles

Book Reviews

Notes and Comments

HARRY A. WILMER, CDR, MC, USNR

People need people

A therapeutic community in a U. S. Navy psychiatric ward

A young man is sitting in a group of 25 patients gathered around a doctor at the U. S. Naval Hospital in Oakland, Calif. In the group also sit hospital corpsmen, nurses, a social worker and a clinical psychologist. This is the community of people—patients and staff—in which the man will begin to recover from his first psychotic break. His chart bears a label: "Schizophrenic reaction, paranoid, acute, severe, #3007." This is the admission ward of the psychiatric service, where patients remain for 10 days before being assigned either to locked or unlocked wards. It is a period of indoctrination and adjustment to the hospital and to their status as psychiatric patients.

This young man is sitting now in a large ward with 17 beds lined in a row along each side. In the group are almost all the professional and non-professional people he will see during the day. The group is quiet —for 10 minutes no one speaks. It brings to mind a Quaker meeting. People are very much aware of people. The staff observes the patients; the patients observe the staff. Half a dozen of them are hearing voices of people who are not there. These hallucinatory voices call the "hearer" names, tell him to do things or tell him that things are going to happen to him, or whisper his name, like his mother's voice coming out of the night when he was a child.

All these patients are locked up in a

At present Commander Wilmer is assigned to the Naval Medical Research Institute, National Naval Medical Center, Bethesda, Md. There he is writing a book on social psychiatry based on the deeply-felt experience described in this paper. The opinions and assertions expressed in this paper are Commander Wilmer's own and are not to be construed as official or reflecting the views of the Navy Department or the Naval service at large.

"closed" psychiatric ward of which I am the ward medical officer. They are seamen and rated sailors, privates and rated marines, staff sergeants, chiefs and today there are two naval officers. They are all patients together, though they have not forgotten their military status. They have gathered for their daily community meeting—a special sort of group therapy—a meeting that lasts 45 minutes and is held at the same time six days a week. On one occasion the entire time passed in total silence. Usually the sessions are quite lively and often follow the threads of ideas from day to day.

This young man, who previously had been considered violent, suicidal and homicidal, who has spent the better part of his previous hospital stays locked alone in a cell called a "quiet room" where he could converse alone with his voices, undisturbed by the voices of reality, unbothered by real people whom he could see, touch, speak to, eat with and listen to, is now in a group. The silence presses in upon him although this is his first meeting, he having arrived from the Far East by airplane only yesterday, his wrists in leather restraints, tied by a waist restraint to the litter, his feet bound together.

When he had been brought to this ward he was at once untied, for restraints were never used here. Walking toward the ward, he had looked into the sinister little slot-like windows of two former "quiet rooms." One was now full of office furniture; the other contained a piano and other musical instruments. "We don't use the quiet rooms on this ward," the nurse said softly, matter-of-factly, to him. He looked doubting. For a few days it was his privilege to doubt.

Patients sense at once falseness and insincerity. Every patient admitted to the ward is seen within an hour by the ward medical officer if he is in the hospital, this despite days when 10 to 18 new patients are admitted at one time. There is a list on the ward bulletin board for patients who want to see the doctor individually. Patients write their names and are seen within 48 hours, and their names are conspicuously checked off for all to see. In this way it is impossible to promise to see a patient and to forget.

Suddenly, in the group meeting, he felt comfortable enough to talk about the "voices." Looking at the doctor but talking to the patients, he said, quivering with excitement, "God tells me I have to go home to save my brother and my father. He talks to me and says if I don't get home in two days it will be too late. My brother is going to do something terrible and I must go to my father because I have done bad things—I must save them. . . ."

From the attentive, silent group suddenly he is interrupted by the staccato voice of a Marine corporal.

"And yourself."

He thinks, *Yeah, and me too.*

Another patient speaks up. "What's the hurry? You're a patient like the rest of us. Wouldn't it be better to get well first here, and then go home to help others?"

He thinks, *Get well.* . . . He wonders, for he doesn't believe he is sick.

"But God tells me—"

"Then pray," commands an old Navy chief. "When Ike was sick, the nation prayed and he recovered. There is power in prayer."

"Ya gotta look out for number one, buddy, before the others," says a young angry Marine out of the side of his mouth.

"The question is," interrupts another, looking at the angry patient, "are we our brother's keeper?"

"But there's nothing wrong with me," says the first young man. The laughter is easy and friendly. He blushes and wonders.

Silence falls on the group, and after awhile the doctor breaks it. "Yes," he says, "are we our brothers' keepers?"

"Who are our brothers?" asks a Negro sailor.

"Yeah, that's a good question—aren't we all?" says a shy young man.

The first young man speaks again. "My brother will die if I don't get home in two days."

"You could be wrong," says another patient.

"Could I?" He speaks more to himself, then adds, "but the voices—they couldn't be wrong!"

"Could be!" Another schizophrenic patient sings out the words between his own hallucinatory voices, then retreats into his shadows and voices again. The face of the first young man shows a momentary flash of doubt, but he is silent.

Like alcoholics talking to alcoholics in AA meetings, here the mentally ill talk to the mentally ill in a way a doctor probably never could. The group continues talking and the doctor listens. But he is thinking . . . thinking that the patient who said "could be" had not spoken a word for five days to anyone; thinking that on a patient's first day on this ward he felt free to begin a group discussion talking about voices; and no one in the group ridiculed or laughed at him, joked or tried to argue him out of his strange experience. They had, rather, dealt with the meaningful content of the messages he was receiving: about helping and praying, about impatience and waiting, about accepting the reality of "not yet" and "here and now." They were persuading and gently arguing with him. These men, with an average schooling not beyond the 10th grade, were talking like sophisticated therapists—kindly, intuitively, honestly, firmly. And some were silent and some sicker than he.

Then, in the listening corner of his mind, the psychiatrist heard the topic change to "good and evil" and heard another patient say with great feeling, "I am evil. I am bad, worthless. I have never been good for anyone. I don't deserve to live!"

"In whose eyes, Roger," come the soft-spoken tones of another patient, "did you have to debase yourself as a child?"

"Bang!" says a schizophrenic patient supposedly living in another world.

"Bull's-eye," Roger says, with an uneasy laugh, and begins talking about his father.

So the group moves to its end. Afterward the staff gather in the psychiatrist's office for their daily half-hour meeting to discuss the group and its patients. They read the letter from the night crew telling how the ward had been in the night watch. During the staff meeting the patients gather in clusters on the ward and continue the discussion or talk about the staff. Such frequent meetings permit feelings to come out into words before they erupt in actions.

This is the day's beginning on a receiving ward in a Navy psychiatric hospital. It is the bringing together of people. It is an understanding of what Robert Frost meant when he wrote:

"Something there is that doesn't love a wall,
That wants it down!"

Its simple premise is that to live a good life, people need people; that to recover from mental illness, people need people even more; that the good in a man must be encouraged, fostered and approved, or else someone will exploit the bad. Except in extreme emergency, to isolate people in padded or unpadded cells makes them sicker; to restrain them makes them afraid, angry and more aggressive; to sedate them with sleeping medicine confounds and compounds their confusion. A sense of belonging, of relatedness, of togetherness can never

come out of a patient's withdrawal, for we must find the areas where he can be reached and give him a helping hand, not push him farther into his sickness. We must not drive him to aggressive acts by unnecessary restrictions, limitations, locks and small closed places, by innumerable small acts that only mean we cannot trust him and therefore he has good reason to doubt his own self-trust.

The community meetings and the methods of psychiatric hospital treatment were called the "therapeutic community" in a book by the English psychiatrist Maxwell Jones. In this concept, all the patient's time in the hospital, 24 hours a day, is considered therapy.

Early in 1955 the Navy sent me to England, where I revisited three famous mental hospitals near London which I had first seen in 1950. Dr. Tom Main at the Cassel Hospital operates an unlocked neurosis hospital. Pre-school children live in rooms with their mothers. It is a democratic hospital in which the roles and attitudes of the staff are under as intense scrutiny as the patients'. Here they had learned that often sleeping pills are given to anxious patients because we doctors and nurses cannot tolerate *our own* anxiety. Unwilling to allow our patients to face sleepless nights because they may make *our* nights sleepless, we put them to sleep. At Cassel Hospital sleeping medication has largely been discontinued.

Dr. Main's experience in a military hospital in World War II he described in an article as experience in "a therapeutic institution."

The second English hospital is Warlingham Park, where Dr. T. P. Rees runs a famous state hospital with no locks; it has a capacity of over 1,000 patients. There is intensive group therapy and emphasis on the hospital as a community. "No locks?" I asked. "What do you do if a patient gets violent?" Dr. Rees regarded me over his crescent-shaped glasses and replied, "They don't." It is difficult to say what I most truly learned from Dr. Rees but it was probably *trust* in people, whether or not they are psychotic; and also that patients must be able to trust the staff. It was clear to Dr. Rees, as it became clear to me, that occasionally patients are locked up not in the interest of therapy but punitively.

At Belmont Hospital, Dr. Maxwell Jones operates an unlocked social rehabilitation unit as a therapeutic community for psychopaths. Most of his patients are the social failures—the thieves, prostitutes, delinquents and criminals from London, sent by the courts. Here they are treated with humane dignity. They are particularly freed from their slavery and bondage to dissocial and antisocial behavior. A majority have been chronically unemployed but a significant percent are returned to society to hold steady jobs. It is here that the therapeutic community functions at its exciting zenith. The element of trust is the highest goal where there is striving for open and free communication between patients and staff, staff and patients and within each group. The idea is that there should be a feedback of all information in the community, a verbal sharing.

There was value in daily community meetings, of daily staff meetings. What skilled therapists, what gentle, perceptive, penetrating helpers patients can be to each other! And what great value was Dr. Jones' corps of non-professional young women trained as "social therapists."

The dignity and freedom conferred on the "worst" of people was quickly earned here. The group culture demands of its members and gets a high degree of good behavior and a high degree of social con-

formity. Here patients who for 20 to 30 years have failed to realize the social consequences of their behavior (that is, that when they do or say something it has repercussions in other people), who have failed to mature, remain for intensive treatment for six months to a year. During this time emphasis is placed upon group living, group meetings and meaningful work: carpentry, painting, gardening, tailoring, maintenance, etc. These people who have been destructive in society are subjected to intensive therapy in a sort of "pressure cooker" way, accomplishing in a short period what long-time conventional treatment would do.

Dr. Jones is a man utterly dedicated to his work. He is showing to those who can see that the belligerent psychopath, under favorable circumstances, will behave as you might hope he would.

These ideas and feelings (and many more) I brought back to the U. S. Naval Hospital at Oakland. There Capt. D. C. Gaede, chief of the neuropsychiatric service, assigned me to the locked receiving ward of 34 beds housed in a temporary wooden structure. Instructions were simple: In addition to carrying the routine responsibilities of a medical officer on a locked receiving ward, I was free to organize the unit as I wished.

The staff of the receiving ward was called together and told the plan: Eliminate the use of seclusion rooms; eliminate so far as possible all sleeping medication and all intravenous and intramuscular injection of barbiturates; no physical restraints of any kind would be tolerated on the ward—no restraining beds, belts, ties, cuffs, cold packs or locked rooms. There would be daily community and staff meetings.

"What will we do if someone becomes violent?" they wanted to know.

"They won't," I replied with borrowed conviction.

One of the healthy contributions of military psychiatry is its saying to patients: "It's your problem, face it"; civilian psychiatry often says: "It's your problem, solve it." The difference is subtle but enormous. To face a problem involves other people, social group experience. A soldier sent back to the front line, though his anxiety be under only moderate control, may not solve his problem, but "sure as shooting" he will have to face it and face his own group. Moreover, he is sent back with the expressed or tacit encouragement that someone important "believes he can do it," that is, "believes he can control himself when he fears he is going to go to pieces."

The relationship of this to our non-use of restraint and the seclusion room is obvious. When a patient says he cannot control himself, he is afraid he is going crazy and will do something terrible, we are not frightened; neither do we act to confirm his testing words of fear. We do not put him in a quiet room where he has a "perfect right" to *act* crazy. Rather, we demand of him a return to community life, telling him that nothing will happen, he will not lose control of himself. But the validity of the proposition is directly proportional to one's belief in it. If you don't believe it, it won't work. If the doctor doesn't work closely with the nurses and corpsmen until they believe it, it won't work. There is nothing magic about good human behavior —it simply takes a lot of hard work, belief in people, caring for people.

Between July of 1955 and April of 1956 when the experiment was discontinued, 939 patients passed through the acute receiving ward, remaining for an average stay of 10 days. This was a constantly changing group

with 44.4% suffering from psychoses, 26.6% from psychoneuroses, 28.3% from character and personality disorders and 0.7% from acute situational maladjustment. For the first four months we used the new tranquilizing drugs sparingly (in 10.8% of the patients), for we wanted to know whether the therapeutic community would work mainly by human efforts. When we found it would we began to use increasing amounts of these drugs, so that in the last four months of the study 27.9% of the psychotic patients were on these drugs at a given time. The drugs had limited but real value.

Not once did I find it necessary to put a patient in a seclusion room or to restrain him. Only three times did I find it necessary to give barbiturates by injection (to two patients with catatonic excitement and to one in an alcoholic psychotic furor). On five occasions the officer of the day put a patient in a seclusion room during the night, but the patient was promptly removed the next morning when I arrived at the ward. Chemical restraint was not substituted for physical restraint; rather, self-control was fostered in place of *being* controlled. In the first month of the therapeutic community 58 sleeping pills were given; by the fourth month this had been reduced to 6.

In the four months preceding the operation of the therapeutic community 440 patients were admitted to this ward and were given 314 oral or parenteral doses of barbiturates. In the last four months of the study 443 patients were admitted and received 29 oral or parenteral doses of barbiturates, most of these ordered by the officer of the day.

Night-time is a time of fears and insomnia and is best dealt with by talking to the patient. If one expects largely to eliminate sleeping pills—because of developing dependency on them, of thus allowing the patient to escape his conflict and the staff to assuage their own anxiety; because they frequently represent an indulgence by the staff, a gift easier given than denied; because it is part of the magic omnipotent potion doctors dispense—it is better to understand the need for them than to give them, for with understanding and firmness the need diminishes and then disappears.

A patient who was brought to us in a camisole, having, according to his record, "torn up two hospitals and one brig," implored "put me in the quiet room or knock me out with medicine," claiming he was going to go berserk, going to kill somebody, throw a chair or do something violent and desperate. He was told that he wasn't going to do anything of the kind, that we were going to help him control himself. He developed a severe headache from time to time on our ward and talked frequently about going berserk, but after 10 days he realized that he was quite responsible for his would-be violent actions. He no longer needed to convince anyone of his great uncontrollable strength, for we had shown him it took greater strength and greater courage to control violence than to unleash it. As a matter of fact, he was an exceedingly well-behaved patient. He had the best conceivable proof he was not going berserk: he didn't.

As week after week went by it became clear to all of us on the staff that something more than meetings was taking place. It was not merely the transformation of a ward once disturbed with occasional violence, and people in quiet rooms exhausting themselves, destroying property.

We encountered many trying circumstances. We dealt with almost a thousand patients over ten months. One patient required electroshock treatment while on this ward; one made an ineffectual suicidal gesture (a very depressed patient who had

been transferred to our ward from another psychiatric ward in our hospital); we found it necessary to sedate three patients by injection; I prescribed sleeping pills a dozen times or so. The new drugs helped but did not account for the results. Two corpsmen were struck. Neither retaliated but stood firm, quieted the patient and were not struck again. One very psychotic, terrified, delusional patient, while being admitted to the ward and still in his uniform, swung at me. He did not hurt or frighten me but startled and surprised me. He was terribly sick and delusional; the staff and patients worked endlessly with him but it took them three days to persuade him even to eat with the other patients.

It is possible that for a very sick patient or some "criminally insane," seclusion would be a necessary emergency measure. But this would not change the basic concept. Flexible therapy, not rigidity, forms the essence of the therapeutic community; also honesty, empathy, trust and a sincere desire to help people. Without these, no amount of technique, no deep knowledge of theory will make it work. It can work only with the cooperation of nurses and corpsmen and only when the doctor makes them a part of the group. It can work *only* when there is belief that there is always another and a better way.

SUMMARY

A therapeutic community on a receiving ward of a psychiatric treatment center at the U. S. Naval Hospital, Oakland, has been described. Almost 1,000 patients were admitted, 44% of them psychotic. Patients remained for 10 days. No restraints were used; barbiturates were used sparingly, ataractic drugs occasionally. The seclusion room was not found necessary.

This is presented not as a panacea but as one of many possible contributions of social psychiatry. While we have cited a few dramatic illustrations the day by day work was rather simple, friendly and "a job of work." Usually the ward looked and sounded like any medical or surgical ward, and the majority of patients were rational though often anxious or depressed.

ACKNOWLEDGMENT

The author wishes to express his appreciation to Rear Adm. Bartholomew W. Hogan, surgeon general, U. S. Navy; to Rear Adm. John Q. Owsley, commanding officer, U. S. Naval Hospital, Oakland; Capt. George Raines, chief of neuropsychiatry, Bureau of Medicine and Surgery, and especially to the staff of the admission ward, particularly the nurse in charge, Lt. Bethel Greene, NC, USN, and to Rear Adm. D. C. Gaede, MC (ret.), USN.

REFERENCES

T. F. Main, "The Hospital as a Therapeutic Institution," *Bulletin of the Menninger Clinic,* 10(1946), 66.

M. Jones, *Social Psychiatry: A Study of Therapeutic Communities,* London, Tavistock Publications, 1952.

E. Skellern, "Therapeutic Communities," *Nursing Times* (London), 51(April–June 1955).

Harry A. Wilmer, "A Psychiatric Service as a Therapeutic Community," *U. S. Armed Forces Medical Journal,* 7(1955), 640.

Harry A. Wilmer, "A Psychiatric Service as a Therapeutic Community II: A Ten-Month Study in the Care of 939 Patients," *U. S. Armed Forces Medical Journal,* 7(1956), 1465.

Harry A. Wilmer, "Treatment of Mental Illness: Use and Misuse of Sedation and of the Seclusion Room," *California Medicine,* 86(1957), 93.

Harry A. Wilmer, "Operation Breakdown, A Fantasy of a Psychiatric Hospital as an Island," *Hawaii Medical Journal,* 16(1957), 275.

C. DOUGLAS DARLING, M.D.

The multidisciplinary approach to the solution of student mental health problems

Before describing the multidisciplinary approach I would like to mention the framework within which efforts along this line should be established.

The multidisciplinary approach to the solution of college mental health problems includes two main objectives. One is the care and treatment of acute emotional disorders which come in one way or another to the attention of the mental health agency of the student medical service. These cases could be designated as "emergency psychiatric practice." Students with emotional difficulties land on the doorstep of the mental health division of the clinic and urgently demand attention. These cases are well known to all and it will not be necessary at this time to specify the various types of student mental health problems nor to go into detail about the several sources of referral of these cases. Individuals so referred have emotional problems needing diagnosis and treatment and/or diagnosis and referral.

It is not unusual, however, for individuals having problems to affect others living in the college community. This raises for brief consideration the second objective of the multidisciplinary approach. Social repercussions of individual problems occur more often than not in a college setting and affect the health of the group. The public health implication of emotional illness must be recognized in our concern for total health. There is a parallel for this if we look for a moment at physical health, where precedents are already established. In the earlier days of student health, emphasis was placed almost exclusively on preventive and remedial aspects of physical health in college instead of on clinical care. In many

Dr. Darling, who is director of the mental health division of Cornell University's department of clinical and preventive medicine, presented this paper in Minneapolis in May 1956 at the annual meeting of the American College Health Association.

universities this is no longer the case. It is now commonly accepted that one objective without the other is quite ineffective where physical health is concerned.

In college psychiatry, which has necessarily grown like Topsy, clinical services have been and still must be the core of a mental health program. I believe, however, that we are in a position to recognize the true prevalence of emotional disorder and to try to apply the principles of epidemiology and preventive psychiatry to improve the over-all health of the group. In other words, we should accept responsibility for the total public health of the college community.

This is a large task. We get some concrete implications of what this might mean from progress reports made at American Psychiatric Association meetings in May 1955 on two research projects studying the incidence of emotional disorder in the community. Rennie reported on a sample of 200,000 persons in New York City. Only 15% were considered to be completely free of neuropsychiatric symptoms. Of the 85% with symptoms, 5% had been hospitalized for inability to function in the community, 10% were severely handicapped, 20% had moderate symptoms which did not seriously interfere with work and social adjustment and 50% had mild symptoms without noticeable social and economic disability.

Dorothea Leighton[1] reported studies done in a rural community. About half the sample interviewed were found to have neurotic symptoms, 1% were considered psychotic and in only 15% were no mental difficulties discovered.

No similar study on a college campus is available. Such a study is much needed and would undoubtedly produce some interesting data. The studies of Rennie and Leighton only confirm, however, what most of us in mental health work have already expected was the case. We know that there are many more emotionally handicapped students on campus than are now seen in the student mental health clinic. Some attempts are currently being made to find these people in sifting the health records of the entering classes, and there are other efforts with mass psychological testing. Similar processes could be inaugurated for the whole student body if sufficient personnel were available to treat the handicapped individuals once they were found. There is precedence for this in the history of student health. Programs on campus have been effective in identifying physical defects and steps have been inaugurated to provide treatment for these defects once discovered. Thus public health measures for physical health are well known in the college community.

It would be possible to conceive of the college campus as one special community in which full mental health services might be supplied. This would include comprehensive clinical care and full preventive psychiatric programs including teaching, psychological screening, routine consultation for academic difficulty, vocational guidance, professional consultation to college personnel, psychiatric services for faculty and so on.

Not only would such a program contribute concretely to present educational objectives but it would serve as a pattern for the general community once the value of such comprehensive services became generally recognized.

That such a program would be expensive there is no doubt. That the contributions which could be made to education would be most valuable there is also no doubt. That

[1] Dorothea C. Leighton, "The Distribution of Psychiatric Symptoms in a Small Town," *American Journal of Psychiatry*, 112(March, 1956), 716.

such a program would be accepted by students and administration there is in my opinion no doubt. This acceptance has been demonstrated in recent years in the demand for clinical services. Demands on existing college mental health services are increasingly heavy and there is no end in sight.

The matter of financing such a program as the one briefly suggested is no easy task. Let me say in passing that the large expense of establishing a full mental program in colleges should not negate the principle that such a program is needed and worth while. What is best for the health of the individual must eventually come about.

Because I am most familiar with the multidisciplinary pattern now in effect at Cornell University I am going to describe in some detail the organization and function of the mental health clinic in the Cornell student medical service. This mental health clinic has evolved gradually. From the very earliest days of student health at Cornell some psychiatric consultation has been available; for almost 20 years a full time psychiatrist has been a member of the medical staff. Ten years ago the services of a psychiatric social worker were added. For five years a full clinic team of psychiatrist, clinical psychologist and psychiatric social worker has served Cornell students.

It is fully recognized that there are other ways to supply mental health services to colleges and universities. Because I describe in this paper the present Cornell organization in some detail I do not mean to imply that this procedure is necessarily the best for every college or university. Our experience has proved that this clinical organization works well and is the method of choice in meeting our needs.

The mental health clinic at Cornell is part and parcel of the general student medical clinic. Such an intimate organizational relationship automatically answers many questions for the student. The matter of quality of service and professional attitudes is taken for granted. So also is the fact that the services are primarily and specifically designed for him. Some of the stature of the general medical services spills over onto mental health services and this is welcome. Consulting services among the medical staff are expedited. It is our firm belief that the multidisciplinary approach should first include close relationships between the general medical disciplines and the mental health disciplines. This is best achieved when the mental health clinic is an integral part of the student medical service.

Close cooperation between the three disciplines of psychiatry, clinical psychology and psychiatric social work are necessary for optimum results. Combinations and additions within these disciplines can be developed depending on the patient load and the mental health budget. Frequently more than a single psychologist and a single social worker are necessary on a team headed by a single psychiatrist. This is particularly true if an attempt is made to meet the demand for clinical services as well as for research and teaching.

Each member of the clinic team must at times undertake various types of responsibility. Each likewise has his particular role which he himself carries out more adequately than any other role. But in college an absolutely rigid system of procedures relative to intake, testing or therapy cannot be maintained if the patient is to be comfortably and adequately served. Although the psychiatric social worker routinely makes the initial interview when students consult the mental health clinic, there are exceptions to this in the well-run college clinic. Campus referral sources have various degrees of sophistication relative to re-

ferral and sometimes exceptions in intake procedures must be made for this reason. Sometimes a patient feels originally that he can talk only to a man or to a woman and this requires some adjustment in routine procedures.

Ideally the psychiatric social worker makes the initial interview, explains how the clinic works and talks with the student sufficiently to obtain a clear picture of the nature and severity of presenting complaints. He or she also is careful to make clear the confidential nature of all consultations and tests. It may be necessary to have more than one appointment to complete the picture. Information from other college offices must be collected—from the dormitories, the academic departments, the college proctor—as the case may be. The social worker is well acquainted with the college counselors, dormitory chaperones, the staffs of the deans of men and women and the student pastors. He or she becomes the *liaison par excellence* with counselors, faculty and administration, keeping the vital lifeline of communication open to the clinic. No confidential nor medical information is given out, however, except in cases of emergency.

The importance of the initial interview cannot be over-estimated. This sets the tone for everything that may follow. At Cornell the psychiatric social worker usually asks the student to take certain pencil-and-paper psychological screening tests. These tests are later scored by the clinical psychologist or under his direction. We find that these tests are very well accepted by the patient and serve several purposes. The tests provide valuable objective data regarding the patient. Also they often serve as immediate objective evidence to the patient that we are interested in him. They usually give the patient much reassurance. In certain instances they help the patient crystallize his problem in terms that he can later verbalize with relative ease.

We have found that patients are cooperative and understanding when the mental health clinic "system" is explained to them. They are told, in addition to the facts already mentioned, that their situation will be discussed in a conference of the three members of the team. (In emergency cases, of course, this step may be omitted.)

In many cases the psychiatric social worker continues to follow the patient at regular intervals, reporting significant problems in staff conference. In addition to her contribution of activities and skills, the social worker gives the patient a feeling of comfort and security in what otherwise might occasionally seem to be an experience somewhat foreign and at times even forbidding.

The clinical psychologist contributes in many ways to the clinic. He is trained and skilled in research. Through an active research program the psychologist, as a member of the mental health team, comes into closer contact with other disciplines on the campus—the teaching faculty, the social scientists, the statisticians and the medical researchers. In the clinical program the psychologist occasionally makes the original student interview (as do all the team members). He takes responsibility for the psychological testing of patients as it is indicated in specific cases. Not every patient seen in the clinic is given a full battery of tests or anything more than the routine psychological inventory. Only difficult diagnostic problems receive an intensive laboratory work-up. Those patients who are accepted for deeper therapy are frequently so studied. Finally, the psychologist carries many patients in reeducational therapy and psychotherapy.

The psychiatrist must take leadership in

the clinical setting and take final responsibility for decisions and actions. Coordination of effort and integration of services are also his responsibility. Most of his time is necessarily given to psychotherapy, long-term or short-term. General procedures regarding clinical care of patients are reviewed in a weekly conference when new and old cases are discussed. Progress is reviewed in those conferences and further plans for treatment and follow-up are decided upon. The intensity with which treatment is undertaken is discussed and the contributions of the various clinic personnel are coordinated.

In addition to undertaking formal psychotherapy the psychiatrist often deals directly with cases needing immediate diagnosis and decision—for example, student conduct cases.

It has been our experience that students freely and gladly accept the relationship of more than one person in the clinical team. The sense of trust which they perceive between the clinical personnel appears to be internalized by the patient and makes the therapist-patient bond even stronger. It is a joy to see this develop, adding another dimension to total therapy. This experience in adult interpersonal relationship is much needed in the college setting. Students are usually separated from parents at college during treatment. Their attitudes necessarily reflect this and they need much reassurance during any psychological procedure. In this regard a college mental health clinic must differ somewhat from a more impersonal medical organization.

It is important to emphasize that all members of the mental health clinic team be able to work intimately together. The characteristics of spontaneous trust, respect and true friendliness are fully as important as that of individual professional training. Each member of the team must have some general knowledge of each patient seen in the clinic so that referrals of patients can be made easily from one to the other. Also, each member at times assists the others in certain aspects of case management.

I might emphasize at this point that the clinic must be more than just a diagnostic and referral service if it is to fulfill its function and if it is going to survive. To paraphrase a famous poem about a rose I might say: "A clinic is a clinic is a clinic." If clients do not obtain treatment and help they are not going to continue to come. Every single contact with a member of a mental health clinic is therapeutic, but treatment needs to go beyond this, as we all know. Not only is adequate clinical care necessary for the individual seeking relief but the actual reputation of the clinic itself is at stake. Students in college share most of their experiences with each other; no college agency escapes for long either praise or blame. Psychological treatment of some kind must be provided for those who come seeking help. The amount of help to be given in each instance will vary. It will vary from the standpoint of individual need as well as from that of available personnel.

This raises the question of just how much psychiatric treatment can be given in college. None (other than diagnosis and referral) should be given if, during therapy, the student cannot continue to profit from his educational experience or if he cannot maintain his behavior as a reasonably acceptable member of the college community. If deep therapy is undertaken, enough time must be given to do a thorough job in rebuilding acceptable defenses in the place of those personality defenses obviously poor or pathological. Pointing up failure (attacking existing unsatisfactory defenses) does not automatically produce constructive reintegration.

I would like at this time to give a few case histories which will illustrate some of the procedures carried out in the actual clinical operation. No effort will be made to include psychotherapeutic content and of course not every procedure can be illustrated. These cases do show the various ways in which referrals are made to the clinical team and the ways in which members of the team apply their clinical skills in different kinds of cases.

CASE 1

This boy was referred by his academic adviser because of his obvious depression. His mother, who lived nearby, was first interviewed by the psychiatric social worker. From the original interview with the patient it was clear that the boy was actually depressed. He was seen by the psychiatrist throughout the remainder of the term in nine consultations. The social worker occasionally saw the mother. There was considerable improvement by the end of the term. The student was referred to the clinical psychologist, however, for further evaluation and reeducation. A full psychological work-up was made throughout the next few months. Complete clinical recovery was achieved and follow-up has shown continued constructive adaptation.

CASE 2

This girl was referred in her sixth term directly to the clinical psychologist by a student pastor. The psychologist asked her to talk with the psychiatric social worker and the patient was quite willing to do this. She had many problems primarily related to family and socialization. After discussing this situation in conference she was seen by the psychiatrist for evaluation and clarification. Following this she saw the clinical psychologist throughout the term at regular intervals (8 visits) and saw the psychiatrist again at the end of the term. During her senior year she saw the clinical psychologist at intervals (16 visits). She also saw the psychiatric social worker two or three times about her sister who was also in college. She was seen at the end of the term by the psychiatrist and was found to have made excellent progress in terms of self-understanding and self-realization. Many neurotic conflicts had been resolved and she was making important personal and vocational decisions on her own.

CASE 3

This boy, a senior, was referred directly to the psychiatrist by the university proctor because he had been apprehended one night by the city police for a bizarre type of exhibitory behavior. Some weeks before he had been seen about an academic problem by the psychiatric social worker. She had consulted with the psychiatrist about this but no really meaningful formulation could be made at this point. After he was picked up by the police, psychiatric examination did not lead to a clear-cut diagnosis. He was referred to the clinical psychologist for diagnostic appraisal. This examination finally crystallized the problem—latent schizophrenia. Eventually the psychiatrist had to issue an enforced medical leave of absence and recommend treatment away from the university.

CASE 4

This senior girl was referred by a member of the medical staff. Earlier she had refused referral to the mental health or psychiatric division. Finally a referral to the clinical psychologist was accomplished by suggesting psychological testing relative to her vocational goals. It was obvious that

she had serious intrapersonality conflicts with preoccupation, anxiety and depression. She responded spontaneously to the opportunity for therapy, however, and has been seen 18 times by the clinical psychologist in psychotherapy. She was also seen by the psychiatrist, and as a result of this the psychiatrist interviewed her parents from a social work point of view. Unusual circumstances indicated the need for the psychiatrist to act in the role of the social worker at this time. Progress has been steady and constructive. Further follow-up is planned.

CASE 5

This patient was referred to the social worker in her junior year by one of the student pastors who had been seeing her from time to time. She was anxious, tearful and depressed and stated that she had a recurring fear of high places. She was apprehensive about psychiatric therapy and needed much reassurance from the psychiatric social worker. Because of her obvious distress she was asked to return by the social worker for a second visit that first day. She also took the psychological screening tests at that time. She was subsequently discussed in conference and then seen by the psychiatrist seven days later. She had 15 hours of psychiatric therapy over the following four months and was followed about once a month during the next year. Her course at first was stormy but she showed much progress, and has since been graduated successfully.

CASE 6

This girl was first seen in the fall of her sophomore year by the psychiatric social worker. She was referred both by the dean of women and the university proctor because she had been stealing food from one of the stores nearby. After she had been interviewed by the proctor she was seen by the psychiatric social worker who learned that this patient had had a "complex about food" for at least two years. Although she was somewhat concerned about her condition, she was more inclined to brush the whole episode aside. The routine psychological screening tests indicated no severe conscious problems other than "trouble with food." She was seen by the psychiatrist who found severe and deep conflicts relative to food, money and, of course, love. The patient finally realized that she had an emotional problem and was much relieved to have it out in the open and asked for psychiatric help. Her family were interviewed by the psychiatrist and the psychiatric social worker. They were cooperative in arranging long-term psychiatric therapy. At the family's request a medical leave of absence was recommended and a therapist in a city nearby was found for her.

CASE 7

This freshman boy was referred to the psychiatrist by a psychiatric friend of the boy's family. He had had a psychotic episode and had been elsewhere in college. He was first seen by the psychiatric social worker, who talked about his general adjustment on campus and arranged for him to meet the dean and some key personnel in the dormitory. Later he asked for concrete evaluation of his intellectual ability for college work. A test was arranged for him and the results, which were satisfactory, were reviewed by the clinical psychologist. The student was seen by the psychiatrist, who found him woefully lacking in interest or motivation. His prognosis was certainly dim. He was invited to return to see us if he felt so inclined but at that time he was not interested in seeing anyone further. At the end of the term, however, he came

in spontaneously to see the psychiatric social worker. He wanted to tell her that he passed his work and was feeling better.

From these brief case histories and our previous discussion it is obvious that the two major objectives of a college mental health clinic are never separated from each other. Emphasis on the goal of clinical care and treatment implicitly enphasizes the other goal, that of preventive psychiatry and public health.

I would like to quote briefly from *Psychoanalytic Therapy*[2] in that part of the text where the authors talk of the goal of psychiatry. They speak of extending the use of psychoanalytic therapy from chronic cases to acute and mildly chronic ones "with the purpose (in treatment) of arresting the progress of and the expectation of being ultimately able to prevent psychoneurosis. This is the supreme aim of every fiield of medicine. . . . Both therapy and prevention are served in the successful treatment of many cases. Thus the successful handling of an acute neurotic breakdown is prevention in that it might gradually develop into a chronic condition if the course of the disease were not halted. . . . In another way, the relief of any psychoneurosis is preventive in that the intimate associates of the neurotic, his family group, etc., experience relief also."

Health services which are laying plans for such a comprehensive mental health program must recognize and deal with increasing demands for services. There are two main reasons for the increase in the demand for mental health services in colleges. The first is that seeking relief for emotional pain has become more acceptable. Having psychiatric treatment is no longer a disgrace nor, indeed, something to be hidden. The emotional cause of symptoms is now more widely accepted by both the laity and the medical profession. The physician is not ashamed to refer the patient for psychiatric treatment and the patient is no longer ashamed to be referred. Many patients refer themselves. More and more it is expected by the public that services of this nature, since they are respectable and valuable, should be provided and made available on the college campus. This trend is general in this country but it is especially noticeable among the well-informed.

A second reason for their increasing demand is that psychiatric treatment *has* something definite to offer in the way of reconstruction, reintegration and reeducation. The "hit-and-miss variety of merely empirical psychotherapy based on intuition and common sense" has no place in dynamic psychotherapy. As the results of treatment in students who are relieved of emotional handicap become known, similar services are sought by others. It is commonplace on a college campus for information of this kind to spread rapidly.

The mental health team of psychiatrist, clinical psychologist and psychiatric social worker has proved to be an excellent approach to the solution of college mental health problems. In every clinical psychiatric specialty—be it that of college mental health, military psychiatry, criminal psychiatry, school mental health or child psychiatry—the *techniques* of adapting general principles of psychiatric practice to the individual specialty will vary. This paper has outlined the multidisciplinary techniques by which sound psychiatric principles can be effectively applied in the college.

---

[2] Franz Alexander and others, *Psychoanalytic Therapy*, New York, Ronald Press, 1946, 11.

MARGUERITE M. PARRISH

Mental health week: a function of the public mental hospital

Mental Health Week is rapidly becoming a recognized institution throughout all the states. During Mental Health Week a concerted effort is made to reach citizens from every walk of life and help them develop a keener interest and greater understanding of the most baffling of the nation's health problems—mental illness. Such an institution as Mental Health Week has its place: Time spent in the development of a well planned program is beneficial to the patient, to the hospital and to the community. It stands to reason that the program is the responsibility of each of these groups.

In reviewing the history of public relations in regard to mental illness, we find two outstanding people, Dorothea Dix and Clifford Beers, who had a profound influence on the mental health movement. They initiated sweeping changes. Dorothea Dix, the Sunday School teacher, and Clifford Beers, the ex-patient, did their part as other citizens have done. The state mental hospitals, however, have been slow to make their contribution and even today some are inclined to blame the community for the lack of facilities, not recognizing that acquainting the community with the need is their responsibility.

If our state hospitals are to solve the problems of shortage—too little space, too few personnel, poor facilities—they must present to the public a clear statement of their needs. This cannot be done by the person responsible for preparing the budget or by any other one person. The job is a big one and it requires dedication on the part of the entire staff. I mean that the hospital as a whole must accept public relations as an obligation in the same sense that it has accepted the obligation to serve its patients. Public relations must be looked upon as an

Miss Parrish is director of social service at the Pontiac (Mich.) State Hospital.

integral part of the total job rather than a minor and often neglected function.

Though public relations is everyone's business some one department must assume major responsibility for planning such a program and coordinating the various activities involved. If the hospital does not have a public relations department *per se,* the first question to be answered is who is going to do this job of planning and coordinating? Social workers, historically the link between the hospital and the community, spend considerable time in the community and as a result are in an excellent position to implement such a program. At Pontiac State Hospital the social service department has emphasized public relations for the last six years and during that time has used the annual "open house" as a sparkplug to stimulate areas of community interest to be developed during each new year of activity.

The interest of the social service department in this particular area of work evolved from the very practical consideration that community help is necessary if mental patients are to continue their progress upon leaving the hospital. When patients leave the hospital they need jobs, places to live and the acceptance of their families and friends. Various programs were set up in the social service department to assist patients in solving these problems, but the effectiveness of the programs was hampered by public opinion. As a consequence, in 1951 the social service department added a public relations program to its list of activities.

The public relations program is a year-round project involving active citizens' committees interested in community education, workshops for police officers and other groups, mental health talks for various organizations, psychodrama and sociodrama, and dramatic presentations on radio and television. Helping patients find places to live and jobs brings the hospital's social workers in constant contact with the community and provides them with an excellent opportunity to shape public opinion regarding the mental hospital and the mentally ill. Volunteers working in the hospital are also an important link in the public relations program. The "open house" during Mental Health Week is, however, the major public relations effort of the year. At this time of year an all-out effort is made to help the community become aware of mental hospitals, their problems and their needs.

All "open house" activities center around tours of the hospital. These tours are conducted by members of the medical, psychological, nursing and social service staffs as well as by patients and volunteers. Visitors are taken to the wards where the patients live, to the recreational therapy and occupational therapy departments, the beauty parlor, barber shop, library and various clinical departments. They are given ample opportunity to observe patients as they participate in various work and recreational activities. At the beginning of each tour a general explanation is given about the hospital, its staff and the various services available to patients. A more detailed explanation is made on visiting specific departments or clinical units. At the end of the tour, time is provided for questions and answers. Special programs, exhibits, discussion groups, mental health movies and workshops are planned in conjunction with the tours to give a well-rounded picture of the hospital, its functions and its role in the community.

Prior to 1951 "open house" received very little publicity and was usually attended by several hundred people. In 1951 the project was turned over to the social service department and has remained a function of

the department since that time. With greater advance publicity the number of visitors has increased each year and has now reached approximately 9,000. Chart I illustrates the increase in visitors from 1951 through 1956.

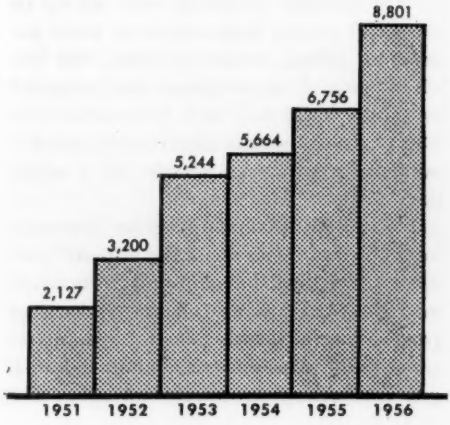
Preparations for "open house" begin several months in advance of the actual date. Various media of mass communication are used. As soon as a decision is made as to the nature of the message to be communicated, plans for presentation of the material are initiated. All possible avenues must be used to present the material, but too many and too varied messages must not be given at any one time. During 1956 the slogan was "The Mentally Ill Do Get Well." In carrying on such a program we must guard against oversimplification. The public is not one vast amorphous organism. Plans must include methods of reaching each of the many types of public with which we deal. Each type of public has its particular set of values and prejudices and the approach to each must be individually tailored. Now who are these publics or these people whom we must sell if we are to have a mentally healthy community in our future?

First of all, there is the public represented by those employed to work with the mentally ill and those who volunteer. Next we have the public represented by those who are in the field but who are not giving direct service to the patient—the mental health commission, the legislature and other public officials. We also have the public represented by those in the professions close to psychiatry: social workers, doctors, ministers, teachers, nurses, etc. The patients and their relatives represent another facet of the public whose support is important. Last of all we have the public at large, represented by those who are not close to the mental health program. This group, representing a sizable part of the population, is of the utmost importance. Each of these parts of the public must be approached, and because the reactions of the individuals making up these groups are varied each must be approached in several different ways. Some members of the various groups are sympathetic, some are basically hostile, some are interested and some are apathetic. To reach all these people, publicity material must be skillfully designed so as to communicate our appeal to many intellectual and emotional levels of comprehension.

Now what about those who are going to carry out this project? They should have an intimate knowledge of the field and its problems, pleasing personalities and the ability to give freely of themselves. Those interested in a 40-hour week cannot carry on such a program because the activities are sporadic and cannot fit into a convenient 40 hours each week of the year. It is also important that they be tolerant and understanding, have an appreciation of the

CHART I

Mental health week attendance 1951–56



prejudices that people carry, be patient and sufficiently secure to accept criticism. Above all, they must have conviction. No matter how well informed they are, unless their discussions, speeches and writings ring with sincerity and conviction their work cannot be effective. All who are involved in such a program must deeply believe they are involved in something vital, valid and meaningful and they must refrain from being apologetic.

The next point to consider is how these carefully chosen people are going to reach the public with their all-important message. One answer is that everyone likes a story. Mental hospitals provide numerous and varied case stories and any one of them contains material that is factual in nature and capable of producing a sympathetic response. The story must be told simply and must be to the point. Treatment which required hours and months and involves pages of professional recording must be condensed into a brief report on the air or into a press release of two or three pages. Treatment techniques must give way to the dramatic. There are people who say they want nothing to do with any kind of publicity. What they are really saying is that they want to do the kind of work they find interesting and do it at public expense without accounting to the public. They must get over that idea; we owe it to the taxpayer to acquaint him with how we feel and think and with the kinds of help we need in order to do a better job. These people must also stop thinking about themselves and think about the patients and the people in the community whom they are bound to serve. Yes, publicity brings criticism, but any major contribution to society brings criticism. So long as we think about ourselves rather than the patients and so long as we are indifferent to or afraid of public opinion we cannot expect support for our programs nor acceptance for our patients when they return home.

The story must be presented. The next question is: How is it to be presented? Whatever the form—case story or simple presentation of facts—we must constantly be aware of the language we use. We must use familiar words and must guard against using them in unfamiliar ways. To most people the term "relationship" means brother, sister, aunt or parent, but to the psychiatrist, psychologist or social worker it describes feelings that exist between two people. We must also remember that to most people "block" means a city square and to only a few of us does it describe a psychological pattern. When one is writing for the general public people must be angry rather than hostile and they must be plain worried rather than have feelings of guilt.

Another point we must keep in mind is that we must meet the public at its various levels and we must travel slowly with them along the route of understanding and acceptance of mental illness. Staff members who stipulate the groups they want to work with are of no help in public relations. When they say, "I want to take an interested group on tour" or "Those kids laughed and made fun of the patients; we should not have to bother with them" or "Why bother with them? They are just curious," they are a detriment to public relations rather than a help. The uninterested and "those kids" and the curious are the people who really need to be reached, and we can reach them only if we are tolerant in our attitudes and try to *understand why* they feel as they do.

And now, in detail, what does it take in the way of letter-writing, speech-making and publicity to draw 9,000 people to a mental hospital during a 4-day period? In 1956 approximately 6,000 letters or printed in-

vitations were sent to key people in the ten counties serviced by our hospital. The key people included the presidents of fraternal, social and business clubs, leaders of churches, schools, hospitals and unions, professional people and public officials.

Printed invitations to our "open house" were sent to professional people and individuals. Letters were sent to schools, organizations and groups requiring specialized information. Not all letters were sent by the hospital. A B'nai B'rith leader, a Catholic priest and the president of the local chapter of the National Association of Social Workers helped in organizing specialized programs and assumed responsibility for contacting their particular people.

Because the young people of today are the parents, educators and leaders of tomorrow special programs planned to meet the needs of this vast segment of our population are particularly important. Pontiac has accepted this responsibility. Prior to Mental Health Week social workers visit the schools, talk with the students in general assembly and in their classrooms and prepare for the day the students spend at the hospital. In many instances the teachers as well as the students are in need of information about the problems of the mentally ill and of the mental hospital; several years of work with the teachers has at times had to precede work with the students.

In 1956 an essay contest was an added innovation to induce students to put all possible effort into learning about the hospital and the problems of the mentally ill. Cash prizes totaling $260 were donated by interested community organizations for the best essays entitled "What My Visit to Pontiac State Hospital Meant to Me." The first prize was $50. The response was most enthusiastic and stimulated the students to considerable research and reading. A workshop on careers in the mental health field was another Mental Health Week feature aimed at the interests of students. Approximately 200 young people participated in this workshop and many expressed interest in having additional workshops.

Workshops were also conducted in 1956 for adults. Approximately 800 attended workshops on the care and treatment of the mentally ill, problems of the aged, and children in trouble. This was the second consecutive year for these workshops, to which all organizations—professional, religious or social—were asked to send representatives. The representatives were in turn asked to take information back to their organizations. The speakers included prominent community leaders as well as hospital personnel. At the close of the workshops all the groups came together in the hospital cafeteria for a coffee hour, with patients as hosts and hostesses.

The Macomb County Citizens' Committee for Pontiac State Hospital, an organization devoted to community education and to making life more comfortable for the hospital patient, also worked diligently toward the success of "open house." The committee represented the hospital at the Utica Health Fair, organized a car pool for the benefit of all who lacked ready transportation, distributed posters and programs and asked each of their more than 100 members to make ten telephone calls in an effort to interest others in the "open house." All these activities followed a workshop on mental health education which was sponsored by the Citizens' Committee. One hour of the workshop was broadcast over the local radio station.

Spot announcements were made on 14 radio stations and on 3 television stations. Ten TV and 16 radio programs, varying in length from 15 to 60 minutes, were also presented on stations serving the hospital area.

The press was cooperative as usual and

generously publicized our "open house." Editors of 50 newspapers were contacted and all published articles. Many of the newspapers ran a series of articles and several published a series of pictures. We found pictures to be one of the most effective ways of telling a story. News releases geared to the needs of big-city daily papers and small-town weekly papers were typed and mailed. A short time after the releases were mailed, a member of the social service department visited as many of the newspapers as seemed indicated and made personal contacts with key staff members. Representatives of the various papers were invited to visit the hospital to discuss such material as was considered important enough to warrant the travel and time of the newspaper men. We felt that when busy newspaper men travel to pay us a visit we must provide an important, colorful and dramatic story—one to which a blanket news release could not do justice. In working with newspapers it is of utmost importance that the individuals dealing directly with the press feel free to make decisions. A good opportunity can be lost, a good story can lose its news value if a decision cannot be made regarding the release of material without returning to the hospital and checking with the administration.

Programs and posters were also put into use. These were strategically placed in schools, libraries and other public buildings. In several of the local grade schools the teachers talked with the children about the hospital, arranged for the school bus to tour the grounds so that the class could see the hospital and then asked the students to take leaflets home to their parents. This is an excellent medium of communication as most parents are interested in the material their children bring home from school.

The occupational therapy and recreational therapy departments contribute to Mental Health Week in a very special way. Besides keeping their departments functioning, they develop specialized activities which not only demonstrate the skills of the patients, but have tremendous public appeal and draw many people to the hospital. The exhibits of paintings and ceramics prepared by the occupational therapy department are very popular. The annual show presented by patients under the auspices of the recreational therapy department is looked forward to as a community event. Two or three performances are given each day and at each performance the 500-seat auditorium is filled to capacity. At many performances standing room is not available. The department usually presents a musical variety show, but 1-act plays written by the patients and portraying hospital life have also been presented. These performances not only draw the public to the hospital but demonstrate the skills of the patients and help to teach the public that mental patients are thinking and feeling individuals with a sense of humor and a wealth of knowledge.

Prior to and after the performances of the patients' play mental health movies are shown and one of the social workers discusses new developments in the field of mental health. The program of activities in the auditorium is continuous and makes use of a variety of educational methods.

The program in the auditorium is organized so as to reach the people making up the following five basic community institutions: the family (parents and children), the church (pastors and lay leaders), the schools (administrators and teachers), community services (social workers, public health nurses, etc.) and employers (managers, supervisors and foremen).

Genuine education consists in motivating people to want accurate knowledge and in

helping them make rational use of it. Mass approaches help them to want it, and that is the aim of Pontiac State Hospital's annual "open house." It also serves as a mass method of destigmatization by bringing the public into close contact with mentally ill persons and removing some of the mystery surrounding mental illness. To efficiently accomplish this end, it is important that patients be actively involved in all phases of the program. When patients are helped to feel a part of the activity and given some understanding of its philosophy and importance they do not resent visitors and frequently derive personal help from the activities.

Throughout the other 51 weeks of the year public relations must continue to be looked upon as important if we are ultimately to reach our goal. Such a program cannot be put on today and taken off tomorrow if real progress is to be made. The successful program must be continuous and must provide for the individual as well as the mass approach. It must take into consideration the motivation and behavior patterns of the public, and the people responsible for the program must have sufficient professional security to forget themselves and to continue the battle in spite of difficulties. The habits and prejudices of a lifetime are not changed by information alone; emotional changes are slow, and key people are not easily motivated to action. The job, however, can be done, and those who really have the interests of the mentally ill and the welfare of the community at heart will see that it is done.

MORTIMER SCHIFFER

A therapeutic play group in a public school

The play group project described in this article was initiated as part of the guidance program of a public elementary school in New York City. The guidance coordinator assigned to this school and many others in the district was concerned with the significant number of emotionally disturbed children whose needs could not be assessed in the classroom. Although she helped the teachers develop the guidance knowledge and skills with which they might deal more effectively with some of the problems, it was evident that there were many situations to challenge even the most experienced teachers.

The school used the clinical agency of the Board of Education, the Bureau of Child Guidance. One social worker and one psychologist were available, but they were also responsible for clinical service to many other schools. The limited services of a psychiatrist of the bureau were generally fully absorbed by emergency referrals. The facilities of community agencies were usually unavailable because intake was closed sometimes for as long as two years. Another major cause for concern was the fact that many parents were totally unreceptive to offers of help. They either refused to recognize a problem or were overwhelmed by so many pressing problems of daily living that their children's maladjustments seemed trifling in comparison. For many parents recently arrived in this country language barriers and general unfamiliarity in a new setting were major factors in their resistance.

The school in which the play groups were developed is located in a slum area honeycombed by industrial establishments. A new housing project represents the most recent improvement in an area otherwise

Mr. Schiffer, a consultant to the New York City Board of Education, developed this article in collaboration with Daisy Hicks and Shirley Walker, play group leaders, and Jeannette Busch, guidance coordinator.

blighted by decayed buildings. There has been a rapid shifting of population in recent years. The high incidence of delinquency is further accentuated by a recent influx of gang groups. In many families both parents are employed and children are either left unsupervised or are poorly provided for by neighbors committed to their own difficult family duties. Many families are supported partially or wholly by the welfare department. Community resources are limited. A day nursery is operated in the housing project and afternoon play centers are found in some of the neighborhood schools.

The public school mirrors the neighborhood. Children bring to the classroom the effects of family discords and neighborhood tensions. Teachers and school administrators are often faced with problems, both tragic and seemingly insurmountable. The primary educative function of a school thus becomes amplified to the point where it is often faced with problems more fittingly the responsibility of social workers, psychologists, psychiatrists, welfare investigators, police, *ad infinitum*. Unfortunately there are still some who unrealistically expect teachers to fill the professional boots of such specialists. The clinical and guidance personnel assigned to the school were aware that some children required intensive therapeutic service. The reality situation was also obvious: the services were not there because of the limited clinical facilities.

The guidance coordinator, a woman dedicated to helping children in need, decided to experiment with a specialized group technique. With the approval of the director of guidance, the principal of the school and the assistant superintendent of the district she organized special play groups of children for whom no other services could be procured. At first the groups were conducted without the supervision of a person trained in group therapy and group dynamics. After a short time the guidance coordinator realized the need for professional supervision of the project, which had quickly revealed many complexities. The writer agreed to act as consultant.

Several teachers volunteered to lead these groups and the principal adjusted their work schedules so as to free them for an hour each day to conduct their groups. The psychologist and the social worker arranged their schedules so that they would be in the school the same day.

Supervision meetings involving all personnel concerned with the project are held once a week over the lunch table. At these meetings all aspects of the project have to be dealt with: intake, group organization, supplies, analysis of verbatim group reports, evaluations, etc. Also attending the supervision conferences are the classroom teachers, whose attendance is voluntary. (It is interesting to note that some teachers who met voluntarily with the group later asked to conduct play groups.) The conferences are conducted in seminar fashion with all members of the group participating in a dynamic learning experience. This structure is more acceptable to educators than the less familiar clinical-type conference.

The consultant supervises the conferences and is responsible for helping the group leaders and others associated with the work understand the meanings of behavior as exhibited in the play groups. This consultative responsibility also extends to the teachers, who may visit the supervisory sessions either because of casual interest or because some of their pupils may be in the play groups. Because such visitors are generally unprepared for the business at hand they require orientation and reassurance, particularly when their own students are being discussed.

The interpretation of dynamics, both group and individual, is an intricate and subtle process and teachers soon learn that apparently obvious explanations of behavior can be misleading and sometimes invalid when exposed to critical examination. This creates anxiety and insecurity, particularly in the play group leaders, who are concerned with developing correct techniques. Their insecurity can be dissipated only through the slow accretion of insightful understanding of the complexities of individual and group behavior. This learning process becomes the major responsibility of the consultant, who must motivate and sustain interest, direct inquiry into proper channels of investigation and be alert to subjective interpretations which threaten critical judgment.

A room was set apart in the school building for the exclusive use of the play groups. It was furnished simply with tables, chairs, work benches, sandbox, sink, etc. The materials provided for the children's use were the play and construction items common to the lower grades: doll families, doll furniture, paints of various types, easels, sand, clay, paper, toys, games, etc. Woodworking tools and games for older children were also provided.

The play groups are neither programmed nor structured; motivation stems from the needs of the children. The adult in charge is a permissive, accepting, neutral person. Interaction takes place spontaneously among the children and between them and the adult. Overt aggression is permitted within limits acceptable to the children and the setting. Identification and transference phenomena are dramatically revealed in the behavior of the children. Since it is not the purpose of this particular article to describe the dynamics of interaction in the play groups, suffice it here to say that the processes described fully in books and articles dealing with group dynamics are profusely illustrated in the play groups.

Each play group meets for an hour once a week. The adult leader writes a verbatim report following the meeting. At one time as many as eight different play groups met regularly. Most groups are homogeneous in terms of sex, but several for the very young children included both boys and girls. Some of the children have been in groups as long as four years. Some who have finished the sixth grade and moved on to junior high school have often returned to visit their former play group leaders.

One of the play groups had been organized two years at the time of the session reported here and after three and a half years is still intact and meeting regularly. Among the children in the group are Alfred, Jack and William.

Alfred, 8 years old and in the 3rd grade, was referred for help by his teacher. She reported that he was shy, nervous and generally unhappy. At times he was sullen and quarreled with other children so violently that it was necessary to remove him from the classroom. His behavior vacillated greatly. Sometimes he was amenable, almost compliant; at other times he was provocative and abusive. Alfred's parents were seen by the guidance coordinator. They proved to be rigid and unsympathetic and refused to recognize any problem. It was obvious that they would reject clinical help for their son. They resented the fact that they had been summoned to school and implied that the school was over-concerned with the boy.

The play group had been meeting for a year when Jack, 9, also in the 3rd grade, was placed in it. Jack truanted often and roamed the streets in the vicinity of the

school. His father handled this situation by beating him severely. Jack's mother babied him and his father resented this intensely. The parents bickered constantly before the children and at one time the mother abandoned the family, taking Jack with her. There was a subsequent reconciliation with her husband and she returned home. Jack's teacher reported that he demanded an unusual amount of attention and solicited overt expressions of affection from her. He would sometimes follow her in the school corridors and in the street. At times he wrote notes to her, openly expressing his love. He was exceedingly jealous of the attention his teacher devoted to other children in the normal course of the school day. He did silly things to attract attention and also attacked other children without overt provocation. When the parents were seen by the guidance coordinator they acknowledged some difficulty with the boy but refused all offers of help.

William was 7 years old when referred by his 2nd grade teacher. The referral form indicated: "He does not get along well with others, requires an inordinate amount of attention, has frequent temper outbursts and is usually restless and hyperactive." It was extremely difficult to assess the home situation here since the parents would not respond to invitations to visit either the teacher or guidance coordinator. Finally a home visit was made. The parents merely accepted the statement of the problem; they raised no objection to any program the school might utilize in working with their child.

In all instances the parents of the three boys permitted their children to join the play group. As far as they were concerned it was a school matter and they were only too happy to see the last of the bothersome school people.

The following is a detailed report on one of the play group sessions in which these boys participated:

Before the group session that day Alfred, Jack and William each met Mrs. Walker in the hall and each asked her to send for him first. When the time for the group meeting arrived she sent two monitors out. One went to Alfred's classroom, the other to the classroom of Jack and William. The boys arrived together. They entered the room, smiled and said hello. Mrs. Walker returned their greeting.

Alfred said, "Look, Mrs. Walker. I brought my racing car to the playroom today." Mrs. Walker looked at it and smiled. (While Jack and Alfred were talking to Mrs. Walker, William quietly went to the drawing paper and appropriated all of it. He hid it behind the radiator.)

Jack said, "Let me see it, Alfred."

Alfred showed him the car and said, "Let's make a race-track in the sand for it!"

As they went to the sandbox they noticed that some of the Easter decorations they had put on the wall above the sandbox during the last meeting had been torn off and that those that were still up were covered with dried sand.

Jack shouted, "Oh look at the things we put up! The other kids spoiled them."

"I wonder who did that," Alfred added.

Jack replied, "Louis, I bet. I just know he did it." (Louis is in Jack's class and attends a different play group.)

William joined the boys in this discussion and asked, "Did Louis do it, Mrs. Walker?"

"I don't know."

"Well, I guess we might as well take the rest of it down. It's so torn and dirty. Okay, Mrs. Walker?"

She nodded.

Jack and Alfred took it down. Then Alfred began to make a road in the sand for his racing car. Jack came over to Mrs.

Walker. He asked, "Will you write a letter to Miss Carson for me?" (Miss Carson was Jack's teacher, the one he was constantly seeking out, begging for attention, sending love letters.)

This request was overheard by the others. Alfred yelled, "Oh, no—no more of those letters."

William chimed in, "That's right. No more letters. Mrs. Walker, don't write no more letters for him."

Jack withdrew in the face of this. He said, "Oh, okay. Okay! Never mind, Mrs. Walker." He walked across the room and began to watch Alfred.

"Look at this! See the way my car goes along this road I made?" Alfred said. He was calling to Mrs. Walker.

She walked over to the sandbox and looked. Then she returned to the table and continued to paint the Easter baskets she was going to put up to take the place of those that had been torn down. William was hovering near her.

He asked, "Can I help?"

"Yes."

"What can I do? Should I paint these?"

"Yes."

He began to paint. Alfred came over to look. "These are nice. You know what I think would be a good idea? See up there over the oilcloth? We could put some of this long paper up and paint it green for grass."

Jack shouted, "That's a good idea!"

Alfred asked, "Can we do it?"

Mrs. Walker merely nodded.

"Come on, Jack," Alfred said. "We'll take this paper out and measure it and scotch-tape it up." He and Jack took out the big roll of paper and began to unwind it.

Jack called out, "See, William, how we're fixing things up? You never do nothing."

William answered quietly, "I'm painting."

"We need scissors now," Alfred called out.

William got up and gave them one. He remained to help them measure off the length of paper and then cut it.

Alfred called to Mrs. Walker, "Do you have some scotch tape?"

She looked around and told him there was no more.

Jack seemed disappointed. "Oh, shucks! Guess we can't do it now."

Seeing their disappointment, Mrs. Walker said, "Perhaps I can get some downstairs. I'll be right back."

William said, "Who'll be in charge of the playroom while you're gone?" He paused in reflection. "Let's see. Okay. Alfred will be in charge till you get back."

She left the room and returned shortly with scotch tape, green paint and more brushes. When she re-entered Alfred called out happily, "Here she is! Okay. This is the way we'll do it." He took the scotch tape from the table and put it in his pocket. "Come on, we'll have to move these things away from the wall so we can put chairs there to stand on."

Excitement mounted. Jack asked, "What about the telephone?"

"Put it there," Alfred said.

William stated, "We'll put this over here."

Alfred objected, "No, no! This way is better."

"That Alfred! Always has to have his own way," William complained.

Alfred replied, "Oh, come on. We don't have all day, you know. Here, Jack. You hold this end of the paper."

Jack grabbed an end and the three boys climbed up on chairs and began to attach the paper to the wall above the oilcloth.

William: "Pass the scotch tape."

Alfred: "Okay, but just take small pieces. We don't want to waste Mrs. Walker's scotch tape."

The boys soon finished hanging the large sheet of kraft paper. They stood back to survey it.

Alfred commented, "Look. We measured it right."

They continued to admire the job for another moment.

"Come on. Let's get busy painting the grass," Jack said. "I'll work over here," he added.

"And me and William will work over here," said Alfred.

The boys had to get back on the chairs to paint. They were having some trouble because they were painting from the same jar. Mrs. Walker divided the paint into three jars without comment.

Jack smiled and said, "That's much better."

Suddenly Alfred got to the floor and said, "Oh, oh! Everybody get down. Right now!"

"What's the matter?" the others chorused.

"I forgot to put paper on the floor. You don't want to get paint all over the floor, do you? Come on! Get down! Stupid!"

The others got down from the chairs and were soon helping Alfred measure off paper to put on the floor at the place they were working.

Alfred asked, "Isn't that better, Mrs. Walker? See? Now if we drop paint, it'll drop on the paper."

Mrs. Walker smiled in acknowledgment. The boys climbed back on the chairs and began to paint. Alfred just made little up-and-down strokes; Jack and William were painting the whole paper green.

Alfred noticed this. "Hey! You fellows are doing it all wrong. The way I'm doing it is the best way. Your way we'll take all day. You two are stupid! Do it my way," he shouted.

"See that Alfred. Always wants to tell everyone what to do," countered William.

Jack added, "We've started it this way. We can't do it like that. Anyway, I think this looks better."

The opposition was too much for Alfred. "Okay, okay. Do it like you want, but it's gonna take an awful long time, stupid! You'll see."

Once again the boys began to paint, more vigorously now. Alfred covered the paper the way the other two had been doing. William and Alfred worked close together, Jack at the far end.

William laughed, "Look! We're almost finished. Ol' Jack is so slow."

Jack seemed hurt. "Well, you two are working together. I'm all alone over here. Isn't that right, Mrs. Walker?"

Mrs. Walker said nothing and Jack did not pursue the subject. The boys soon finished painting the grass and then began to measure more paper.

Alfred spoke with assurance, "Now, on this paper we'll make houses and things. Mrs. Walker, can you make flowers for us?"

"Yes," she replied, and began to draw flowers on pieces of paper.

Alfred called to the others, "Come on! Let's put this up and then paint the things on it." He started picking up the long sheet they had cut.

This did not seem to be acceptable to William. "No, no, no, Alfred! If we put it up there it will be too high. How can we paint it up there?"

Alfred spoke authoritatively, "Come on. Help me put it up there, stupid!"

"Everything his way all the time," William objected.

Jack insisted, "No, Alfred, he's right. We won't be able to paint it up there."

Once again Alfred gave in. "Okay.

We'll paint it on the floor. I'll make houses at this end and you can work down there." He turned to Mrs. Walker and added, "How are the flowers coming?"

"Fine," she replied.

They began to paint houses on paper. Occasionally one or more would stand back and examine the work critically and comment.

"Now we've made the houses. What else can we make?"

"How about people?"

"You took the words right out of my mouth."

They returned to the work industriously, painting people. William finished his part, walked over to Mrs. Walker and began to cut out the flowers she had painted.

Alfred and Jack attached the flowers to the mural with scotch tape, with Alfred dictating where to put them. Mrs. Walker then got up and helped the boys attach the mural up above the grass they had previously painted. They all stood back to admire the finished job.

Jack said quietly, "That's beautiful!"

"Yeah." William and Alfred agreed.

Jack turned to the others and said, "Remember how we used to come in here last year and break everything up? Now we're so different we're fixing things up nice."

William added nostalgically, "Yeah, we sure used to break things up."

Jack continued, "And Harry (absent this meeting) would say, 'Come on, fellers, stop throwing things around. Fix things up. Don't break things up!' And we'd say, 'Oh shut up, Harry. Shaddup!' "

The boys laughed as they reminisced. Then they began to mop up, rearrange the furniture, wash paint off the oilcloth on the table. Everyone was working enthusiastically. When they finished Jack said, "Gee, this place looks so good! Mr. Dessot (the principal) would certainly be surprised to see how nice we fixed the place up."

"Could you call him up and ask him to come to see it?" William asked.

Mrs. Walker replied, "When we leave here I'll stop by the office and ask him to come up to take a look at it."

Jack was disappointed, "Oh, can't you call him now and ask him to come while we're still here?"

In unison the three boys pleaded, "Please call him."

"All right," Mrs. Walker replied. She picked up the intercom phone and told Mr. Dessot how eager the boys were for him to come up to see how they had decorated the playroom. She talked for a moment and then hung up.

"What did he say? What did he say?"

She replied, "He wanted to come very much but he has something that he must finish now and wouldn't be able to come."

The boys were extremely disappointed. Mrs. Walker attempted to reduce this and added, "He'll come up as soon as he can though, maybe tomorrow."

"By then the other kids will spoil it all," Jack complained.

The boys stood there, dejected. Suddenly the phone rang. Mrs. Walker picked it up, talked for a moment and then hung up. The boys looked at her as if expecting a reprieve from disappointment.

"Mr. Dessot said he will be able to come after all. He'll be right up."

The boys were gay and excited. "Oh, boy! Yippee! William, you look through the peephole and tell us when he's coming. Hurry up! Let's set the table and get everything just right."

"Oh! There's paint on the radiator. We won't have time to wash it off. Gimme the cloth and I'll cover it. Quick, Mrs. Walker, the scotch tape, the scotch tape!"

She gave the boys the tape. Alfred got

busy setting the table for refreshments. William was looking through the opening in the door.

William: "I don't see him yet."

Jack: "Keep looking."

Alfred: "Do you see him? Do you see him?"

Jack: "Maybe he'll sit down and eat with us."

William: "The chair's too dirty!"

Jack: "I'll dust it off!" He quickly dusted off the chairs and put a burlap seat cover on each one.

William: "HERE HE COMES!"

The room became a tableau as all motion stopped. The door opened and Mr. Dessot walked in. Jack hid behind William. All became shy.

Mrs. Walker broke the tension, "Hello, Mr. Dessot. We're so glad you could come. The boys wanted you to see how they decorated the room."

Mr. Dessot smiled, "It looks very nice."

Mrs. Walker added, "They did it all themselves."

The boys beamed. Their shyness lifted measurably.

Mr. Dessot said, "I'm trying to get a bigger room in the building to use as a playroom. You boys have done such a nice job here that we could use you to fix up the new room when we get it."

The boys smiled self-consciously. Although they were happy with the approval they had received their manner was noticeably reserved and lacked the ebullience which had preceded the entrance of the principal. (It is significant to note that this is the first group session to which they had invited any other adult.)

"Well, I have to go now, boys," Mr. Dessot said.

They all replied, "Good-by."

When the door closed after him Jack said, "Come on, let's eat!"

Mrs. Walker sat at the table with the boys, who ate their cookies and drank the milk with relish.

When they finished Mrs. Walker said, "We'll have to leave now because I must go on duty in a few minutes."

William looked across the table and said to her, "Aren't you going to eat your cookies?"

Jack scolded him, "Oh, for Pete's sake! Why don't you leave Mrs. Walker have her cookies sometime!"

The boys helped her clean the table. Following this they accompanied Mrs. Walker out of the room.

Note: This is the first session that neither Jack nor William had requested clay or paper to take with them from the playroom.

Evaluation reports are received periodically from the classroom teachers of these boys and of others in play groups. Some significant changes in behavior were reported by the teachers of these three boys.

Alfred's teacher stated that although he still required a good deal of attention in class he related better to her and to his classmates. At one time constantly provoking his classmates he is now less inclined to do so. He still gets into fights but does not strike out in the vicious manner originally described. He seems to be happier in general.

Jack, who was the last to be placed in this group, has also shown improvement. He is more secure in his relationship with his classroom teacher and has less need to monopolize her attention. His truancy has diminished; he evidently derives more satisfaction from school. He seems to be more friendly.

William also shows improvement in his school adjustment. He has become responsive to attention from his teacher, is more amenable, is now accepted by his classmates

and participates in most classroom activities. His parents still do not come to school and evidently continue in their detachment. It is interesting to note, however, that there have been instances where parents who originally resisted special clinical help for their children later voluntarily sought out the guidance coordinator when they observed the progress made by their children after a period in a play group.

DISCUSSION

The concept of a specialized play group program for the emotionally disturbed child —operating within the public school and using techniques more familiar to the child guidance clinic—is something that should give pause not only to educators but also to clinicians sensitive to the demands of therapeutic processes. The writer does not wish to convey the impression that the play group represents a clinical tool for the complete alleviation of symptoms that have deeply rooted etiology. Nor is it posed that the play group can substitute for ultimate therapeutic treatment when it is required. Nevertheless our experience indicates that therapeutic effects do emerge and many of the children function better in the classroom and in the neighborhood as a result of their participation in the specialized play group.

Children who are deprived in some measure of the emotional security which grows from the love of understanding parents or whose deprivation is acute because they are exposed to even more negative emotional experiences in their homes are in desperate need of positive surrogate identifications. Only with such support can the threatened ego receive some sustenance against the overwhelming impact of destructive forces. The play group is an attempt to meet some of the needs of such children.

IRVING SARNOFF, PH.D.

Value conflicts and psychoanalysis

Those of us who presume to treat the emotional ills of our fellow men are constantly searching for additional knowledge of human behavior. Yet, paradoxically enough, the acquisition of such knowledge tends in some ways to multiply rather than diminish our difficulties, for each new discovery of important determinants of behavior must be assimilated and then somehow welded into our therapeutic armamentarium. Thus before the discoveries of Sigmund Freud burst forth upon the medical world like a torch in the night the treatment of mental distress was a comparatively simple process. One knew little; hence one did little. After Freud, however, most of those charged with the responsibility of psychotherapy felt obliged to acquaint themselves with, if not to employ, the theories and methods of psychoanalysis.

Dr. Sarnoff is an assistant professor of psychology at Yale University.

The impact of new and fundamental discoveries such as psychoanalysis is likely to be so great, especially in contrast to what has previously been known, that practicing psychotherapists are apt to become deeply involved in and identified with them. Although this emotional affiliation is inevitable, even necessary, for proper learning, it may in time obscure the therapist's perception of and appreciation for other developments in the broad field of human affairs. As implied at the outset, this obscuring of one's vision may represent, to borrow a psychoanalytic term, a mechanism of defense against the overwhelming task of reading about, much less therapeutically incorporating, the myriad of facts and concepts which are being produced in constantly increasing quantities. In any case, there are many lags between knowledge and application.

Occasionally these lags stem not so much from a failure to apply freshly uncovered facts as they do from an inadequate appre-

ciation for the significance of observations which have been affirmed and reaffirmed throughout the ages. This appears to have happened in the area to which we shall direct our discussion. We refer to the indifference of many influential schools of psychotherapy to an important source of psychopathology, value conflicts.

Of course the role of values in personality formation and psychotherapy has received considerable attention in recent years. In this regard such psychotherapeutic innovators as Sullivan, Horney and Fromm have made outstanding contributions. Still it may be worth while to make additional attempts to spell out the psychological implications of value conflicts and to bring them into more explicit and functional relationship with the therapeutic enterprise.

Because of its preeminent influence in the field of psychotherapy we shall focus upon the psychoanalytic school of therapy to illustrate our thesis. At the same time we should like to dispel at the outset any implications that psychoanalysis has been more flagrant in its neglect of value conflicts than several other widely employed systems of psychotherapy. Nor do we wish to amplify the unprofitable din of dissent made by those whose essential critique of Freud rests on the unalterable fact that he was mortal and not possessed of everlasting omniscience. Indeed it may even be unfair to imply that contemporary psychoanalysis should be concerned with value conflicts. Certainly, it may well be argued, no school of psychotherapy can encompass every important aspect of life and behavior. Moreover does not a psychotherapist, like any ordinary citizen, have a right to select the sort of work he wishes to do? From the standpoint of a democratic society the answer to such a rhetorical question must be in the affirmative. Nevertheless it does appear that conflicts of value are now such a commonplace source of psychopathology [1] that psychoanalysis, if it is going to maintain its leading role in the history of psychotherapy, must eventually turn its fruitful regard upon them.

Freud's great contribution to public education and welfare was his unswerving emphasis upon the vitally intimate relationship between man's biological drives and his personality structure. Before the publication of Freud's writings members of polite society had all but denied the existence of the sexual aspects of the human organism. In effect, the subject of sex was banned from serious discussion and scientific inquiry. Since those days, however, the insights of psychoanalysis have penetrated and influenced ever-widening portions of the population. In addition to psychotherapists we now have psychoanalytically oriented parents, teachers, social scientists and creative artists. (4)

Since the sexual impulses have been particularly affected by social prohibition and ignorance psychoanalytic therapy is singularly well equipped to help persons in deriving more pleasure from their biological apparatus. By helping to make conscious the impulse tendencies which were formerly unconscious psychoanalysis permits the individual to resolve inner conflicts in this area of behavior.

As the facts of psychosexual functioning were being steadily unraveled by the individual psychoanalyst working with the individual patient the facts of social life were being enacted in a broad and massive panorama. During the years when Freudian

[1] One continues to see patients who appear to have stepped out of the pages of Freud's case notes. Their number, however, seems to be steadily declining while the number of patients who are disturbed by an insufficient sense of personal validity is increasing.

thinking was making its impact on the world social revolutions were actualized, times of economic prosperity alternated unpredictably with dark decades of depression, and international wars were interspersed with periods of fitful peace.

Although the discoveries of psychoanalytic therapy have continued to influence the stream of public thought the facts of social living have had no comparable effect upon the theoretical and technical approaches of most psychoanalysts.[2] As a result orthodox psychoanalysis continues to be practiced without appropriate concern for such important social sources of psychopathology as internalized value conflicts, although their effects may be just as pathogenic as internalized psychosexual conflicts.

Economic, social and political values are manifold and contradictory in modern society. They arise from the nature of our social institutions, which are in a constant state of flux. The growing individual is exposed not only to the value pressures of his own contemporary class and caste but also to those of other segments of society both past and present. For example, the American is urged to love his neighbor and taught that the meek shall inherit the earth; on the other hand, he is told that this is strictly a dog-eat-dog kind of world where none but rugged individuals may hope to succeed. He is encouraged to identify with the go-getters and those at the top of the ladder. Yet if his skin is black he is often advised to stay in his place. His wife's place is said to be in the home, but Hollywood's version of the home is far beyond the grasp of most women.

These are only a few examples[3] of the conflict-inducing values with which the individual must cope and which he must integrate. Needless to say, a complete integration is never accomplished. Just as interpersonal trauma induces the repression of sexual impulses so the impingement of shifting, incompatible social values motivates the conflicted individual to use drastic defense mechanisms in an attempt to achieve consistency. Unconscious values continue to drive the individual in the same way that unconscious impulses find their outlet in symptom formation. While the impulse-conflicted individual may be incapacitated by gross somatic ailments the value-conflicted individual is more likely to complain of vague feelings of confusion, guilt, aimlessness or anhedonia. Thus unless psychotherapy is prepared to deal with value conflicts it must necessarily remain incomplete.

The following case[4] may help to illustrate the general point we have been making: K. G. is a 30-year-old graduate student at the University of Michigan. He is married and a veteran of World War II. Although he possesses an exceptional intellectual capacity and a superlative academic record K. G. tends to fret and ruminate about his work at the university. He lives in constant fear of failure. Examinations fill him with dread and anxiety out of all proportion to their significance. No amount of previous success seems to assure him of his ability to cope with the demands of his courses. K. G. is quite obviously an obsessive worrier, a person who wastes a great deal of time and energy brooding over and

---

[2] It is true that psychoanalysts have been devoting increasing attention to "ego psychology." However, this extension of emphasis of Freud's therapeutics does not cover problems of value *per se*.

[3] See Lynd (5) for an excellent description of the content of major American value conflicts.

[4] Seen when the author was senior psychologist in the department of mental hygiene of the University of Michigan Health Service.

preparing for nameless dangers and insignificant obstacles.

Discussion of K. G.'s family background revealed the sort of deteriorating interpersonal relationships one would have expected to find in support of such gross symptoms. During the course of psychotherapy with him we obtained a picture of parental rejection, insecurity, repressed hostility and attempts at overcompensation.

K. G.'s initial complaints were concerned with his symptoms and their incapacitating effects. His tendency to vacillate was especially upsetting to him. It was in this connection that he brought forth, several weeks after the beginning of therapy, a previously undisclosed difficulty. He reported that he could not decide upon the degree of political activity in which he should engage. His sympathies had always been slightly left of center and prior to his army service he had participated in groups whose political complexion might be described as mildly socialistic. Since his discharge from the army, however, he had become increasingly preoccupied with his own day-to-day affairs and with the rise of "McCarthyism" had been increasingly reluctant to commit himself on political issues. But political values were important to him and he felt guilty and incomplete because he was not expressing them.

Pursuing a career in nuclear physics, he was aware that most positions for which he might qualify would be subject to close security and loyalty investigations. On the one hand, having always suffered from feelings of inadequacy he was vitally interested in attaining success and status. On the other hand, his idealism and political convictions, if expressed, threatened to jeopardize his chances of success. Hence he was caught in a web of ambivalence, a state of affairs which was typical of him.

It is true that K. G. was troubled largely by emotional conflicts which had nothing whatsoever to do with his political values. Conversely his ambivalence towards political behavior was not unrelated to his general pattern of vacillation. Nevertheless we could not doubt that part of the emotional strain he felt stemmed, in fact, directly from the conflict in values in which he was immersed. Indeed even after considerable headway had been made in resolving his more irrational ambivalences the political one remained. He still felt it right and just to maintain a liberal outlook. A more planned cooperative society still seemed worth working for. And the threat of punishment for political deviation continued to plague his thoughts and constrain his actions.

In our psychotherapeutic sessions we discussed his feelings towards his conflicting values. Ultimately he chose to keep out of political action and controversy, to suppress this aspect of his being, in favor of vocational security. In making this decision he realized, however, that he would have to pay for his political inactivity in the wretched currency of self-deprecation.

Other cases result in the opposite sort of resolution, one that favors the expression of political values. Therapeutically of course the important thing is for the patient to know how he feels about his decision and to accept responsibility for its consequences.[5] Ideally, in the absence of external constraints the deciding factor is the extent to which a given set of values is con-

[5] Concerning consequences the author is not as *laissez-faire* as he might appear. For when a patient's political philosophy is a totalitarian one which would, if implemented, enslave other people or abolish their liberty the author regards adherence to such philosophies as pathonomic. Hence he would consider therapy a failure or incomplete for those patients who continue to uphold these views.

sonant with one's self image. Social conditions, however, may be so oppressive as to displace all psychotherapeutic considerations with those of survival. Hence when a political viewpoint is a punishable offense, irrespective of its intrinsically positive human implications one cannot properly say that a patient is free to express it. Indeed there exist other spheres of positive action which owing to situational dangers may also be virtually impossible for some patients to pursue, even if such actions would accord fully with their values (8).

In very brief illustration of another sort of conflict in social values we can cite the case of a married woman who was a talented art student but whose emotional problems impaired her creative activity. Among other things she was torn between her need for an independent career and her desire for the domestic pleasures of a housewife—a clash of role expectations which is fairly commonplace for women in our society.

Before consulting us for help she had seen a therapist who could not, according to the patient, take seriously her artistic aspirations. Instead, as he acknowledged when we contacted him for information about the girl, he had urged her to devote herself more fully to her wifely duties and to relegate her art to the position of a hobby which she might indulge during her spare time. Apparently his concept of the proper role of women collided openly with the patient's image of herself and her potentials. As a result she was obliged to search for another therapist, one whose values could permit her freely and completely to explore her motivation for a career in art.

Fortunately the problem of value analysis has not gone entirely unnoticed by orthodox psychoanalysts. Ernest Jones (3) notes that it is difficult to understand why psychoanalyzed patients and therapists continue to uphold the same social biases, myths and misconceptions as unanalyzed persons. "An impartial observer cannot fail to be struck by the disconcerting fact that analyzed people, including psychoanalysts, differ surprisingly little from unanalyzed people in the use made of their intelligence. Their greater tolerance in sexual and religious spheres is usually the only mark of change in the use of the intellect. In other spheres they seem to form their judgments, or rather to maintain their previous convictions and attitudes, on very much the same lines of rationalized prejudice as unanalyzed people do." Jones feels that these prejudices are extensively influenced by the distorting effects of unconscious complexes and goes on to say that it is "striking to observe how little advantage is commonly obtained from psychoanalysis in comparison with what one knows must be potentially available." Jones then speculates on the possibility of exploring convictions in psychotherapy. He thinks, however, that unlike the situation in orthodox psychoanalysis we must still await the arrival of a pioneer who may shed light on the "relationship of unconscious complexes and social interaction."

We agree fully with Jones on the need to extend psychoanalytic therapy to handle problems of conviction. We do not feel, however, that the exploration of such psychological problems must be delayed pending the emergence of another Freud. Instead Dr. Jones would be well-advised to look backward rather than forward for help in dealing with the difficulties he poses. Long before psychoanalysis was conceived, beginning indeed with Plato and Aristotle and continuing through Marx and Veblen, social philosophers had already articulated many of the crucial relationships between social reality and social psychology (2).

In recent years many social science stud-

ies whose general approach is influenced, albeit often unknowingly, by these social philosophers have focused on the task of relating ideology both to social realities and psychopathology. An example of the first kind of relationship is to be found in Richard Centers' public opinion study (2) which demonstrated that, broadly speaking, an individual's attitudes on a wide variety of social issues may be predicted from knowledge of his objective status in the socio-economic hierarchy. Although this relationship between social attitude and class position is by no means a perfect one it is high enough to show that social differences do indeed lead to attitudinal differences. Interestingly Centers' data indicate that many persons of low-class status tend to see themselves as belonging to more highly placed groups. This apparent distortion of reality is not surprising in view of the fact that neither tangible nor psychological rewards are likely to accrue to those who occupy socially inferior positions. Nevertheless it would appear to be just as pathonomic for a manual laborer to perceive himself as a member of the middle class as it might be for him to be unclear regarding his sexual identification. Thus any system of psychotherapy which is committed to "reality testing" as a desirable goal should be as concerned with social misperceptions as with transference reactions, for just as a healthy patient should be able to discern the difference between his father and his therapist he should also be able to distinguish his identity in the social order from that of others.

Frenkel-Brunswik and her colleagues (1) have investigated the relationship between psychopathology and such social beliefs as ethnic prejudice and fascism. Their studies indicate that these socially destructive attitudes tend to be accompanied by pathological personality structures. Such studies as these are beginning to cast doubt upon those approaches which assume that the patients' ideologies are a matter of no consequence for psychotherapy. On the contrary, it is becoming increasingly obvious that some convictions may mask underlying pathology and that others imply health for the individual and all those with whom he interacts.

In all fairness we should reiterate that the problem we have been discussing does not apply to psychoanalysts alone. Many different kinds of psychotherapists balk at discussing value issues with their patients. They often claim that such issues do not fall within the province of psychotherapy. Certainly we would agree that the job of the therapist is the alleviation of suffering and not the dissemination of propaganda or moral dogma. Nonetheless much of the patient's suffering may stem from unresolved value conflicts. To decide *a priori* not to engage in the analysis of value conflicts even if such conflicts happen to be at the root of the patient's distress is to be an ineffective, if not a dishonest, psychotherapist. Thus the psychotherapist is just as negligent if he fails to deal with incapacitating value conflicts as he would be in ignoring the possibility of organic brain damage in the case of chronic unremitting headaches.

Having decided that it is legitimate and necessary to explore value issues whenever they contribute significantly to the patient's difficulties, the psychotherapist must be careful to minimize [6] the imposition of his own values upon the patient. This can no more be done if the therapist denies he has values than control of counter-transference

[6] Of course, this caution is *per se* an expression of a non-totalitarian ideal.

reactions can be achieved if the therapist denies he has sexual or aggressive impulses. Nor can maximal therapeutic objectivity be attained by becoming a "blank screen" or "mirror," a posture of anonymity advocated by the Rogerians.[7] On the contrary, denial or dissimulation may foster the very effects they seek to preclude, for try as he may to hide or suppress them no psychotherapist can prevent the revelation of many of his values to his patients. Every focus of attention, every question, every statement, every nuance of tone and manner makes some aspect of the therapist's system of values available to the perceptual field of the patient. Moreover the very fact that he has chosen to be psychotherapist and has adopted a particular "school" of psychotherapy is a reflection of many of his major values (10). Finally the process of identification, supported by motives of fear (7) and admiration (9), assures the result that the patient will adopt much of what he perceives the therapist to like or dislike.

Since the passing on of many of his values is inevitable under any circumstances, it behooves the psychotherapist to maintain the fullest possible awareness of his own values and value conflicts. The psychotherapist who attains this sort of self-insight is better equipped to deal objectively with the value conflicts of his patients than the psychotherapist who remains unaware of his own values. No doubt, as psychoanalysis has informed us, the psychotherapist must be cognizant of the patient's difficulty in resolving conflicts in the spheres of sex and aggression. At the same time, however, the therapist should not be insensitive to the way the patient has dealt with conflicts involving social values, for although man is a creature of flesh, blood and lusty impulses he is also a member of society and subject to its emotionally upsetting contradictions in value.

[7] If the Rogerian logic were accepted literally the therapist would be in the position of disavowing interest in the patient's health. Indeed non-directive theoreticians actually uphold this farcical viewpoint when they presume to shift the entire burden of psychotherapeutic responsibility onto the patient. (6).

REFERENCES

1. T. W. Adorno, E. Frenkel-Brunswik, D. J. Levison and R. N. Sanford, *The Authoritarian Personality*, New York, Harper & Brothers, 1950.

2. R. Centers, *The Psychology of Social Classes*, Princeton, Princeton University Press, 1949.

3. E. Jones, "Concept of the Normal Mind," *Yearbook of Psychoanalysis*, II, New York, International Universities Press, 1946.

4. S. Lorand, *Psychoanalysis Today*, London, George Allen and Unwin, 1948.

5. R. S. Lynd, *Knowledge for What?* Princeton, Princeton University Press, 1939.

6. C. R. Rogers, "Therapy in Guidance Clinics," *Journal of Abnormal and Social Psychology*, 38 (1943), 284–89.

7. I. Sarnoff, "Identification with the Agressor: Some Personality Correlates of Anti-Semitism among Jews," *Journal of Personality*, 20(1951), 199–218.

8. I. Sarnoff, "Social Reality and Psychotherapeutic Ideals," *Mental Hygiene*, 39(1955), 26–33.

9. H. Schrier, "The Significance of Identification in Therapy," *American Journal of Orthopsychiatry*, 23(1953), 585–604.

10. W. Wolff, "Fact and Value in Psychotherapy," *American Journal of Psychotherapy*, 8(1954), 466–86.

ELI M. BOWER

Cultural values and the retarded child

Although some progress has been made in bringing the mentally retarded child into the consciousness of the community, values exist in our culture that, to the degree they are present in each individual, make progress in this area difficult. It is the purpose of this article to examine and analyze these cultural values so that they may be raised to a higher level of conscious awareness and thereby be acted upon with greater freedom.

It might be well to begin by explaining the meaning of the term "cultural values" as used in this paper. Cultural values are those values or ideals shared by most members of the culture *that act as directives or prescriptions for behavior.* The values by which a culture functions might be compared to the motives that underlie individual behavior. In both cases the values that act to direct the behavior of the individuals are to some degree unknown to the behaving unit. Values and motives also have compulsive and coercive aspects. Fromm suggests that cultural values "shape the energies of the members of society in such a way that their behavior is not a matter of conscious decision as to whether or not to follow the social pattern but one of wanting to act as they have to act and at the same time finding gratification in acting

Dr. Bower is consultant on mental hygiene and education of the mentally retarded for the California State Department of Education. He delivered this paper in Butte, Mont., in March 1956 during an institute on mental retardation sponsored by several state and federal agencies.

reactions can be achieved if the therapist denies he has sexual or aggressive impulses. Nor can maximal therapeutic objectivity be attained by becoming a "blank screen" or "mirror," a posture of anonymity advocated by the Rogerians.[7] On the contrary, denial or dissimulation may foster the very effects they seek to preclude, for try as he may to hide or suppress them no psychotherapist can prevent the revelation of many of his values to his patients. Every focus of attention, every question, every statement, every nuance of tone and manner makes some aspect of the therapist's system of values available to the perceptual field of the patient. Moreover the very fact that he has chosen to be psychotherapist and has adopted a particular "school" of psychotherapy is a reflection of many of his major values (10). Finally the process of identification, supported by motives of fear (7) and admiration (9), assures the result that the patient will adopt much of what he perceives the therapist to like or dislike.

Since the passing on of many of his values is inevitable under any circumstances, it behooves the psychotherapist to maintain the fullest possible awareness of his own values and value conflicts. The psychotherapist who attains this sort of self-insight is better equipped to deal objectively with the value conflicts of his patients than the psychotherapist who remains unaware of his own values. No doubt, as psychoanalysis has informed us, the psychotherapist must be cognizant of the patient's difficulty in resolving conflicts in the spheres of sex and aggression. At the same time, however, the therapist should not be insensitive to the way the patient has dealt with conflicts involving social values, for although man is a creature of flesh, blood and lusty impulses he is also a member of society and subject to its emotionally upsetting contradictions in value.

[7] If the Rogerian logic were accepted literally the therapist would be in the position of disavowing interest in the patient's health. Indeed non-directive theoreticians actually uphold this farcical viewpoint when they presume to shift the entire burden of psychotherapeutic responsibility onto the patient. (6).

REFERENCES

1. T. W. Adorno, E. Frenkel-Brunswik, D. J. Levison and R. N. Sanford, *The Authoritarian Personality*, New York, Harper & Brothers, 1950.

2. R. Centers, *The Psychology of Social Classes*, Princeton, Princeton University Press, 1949.

3. E. Jones, "Concept of the Normal Mind," *Yearbook of Psychoanalysis*, II, New York, International Universities Press, 1946.

4. S. Lorand, *Psychoanalysis Today*, London, George Allen and Unwin, 1948.

5. R. S. Lynd, *Knowledge for What?* Princeton, Princeton University Press, 1939.

6. C. R. Rogers, "Therapy in Guidance Clinics," *Journal of Abnormal and Social Psychology*, 38 (1943), 284–89.

7. I. Sarnoff, "Identification with the Agressor: Some Personality Correlates of Anti-Semitism among Jews," *Journal of Personality*, 20(1951), 199–218.

8. I. Sarnoff, "Social Reality and Psychotherapeutic Ideals," *Mental Hygiene*, 39(1955), 26–33.

9. H. Schrier, "The Significance of Identification in Therapy," *American Journal of Orthopsychiatry*, 23(1953), 585–604.

10. W. Wolff, "Fact and Value in Psychotherapy," *American Journal of Psychotherapy*, 8(1954), 466–86.

ELI M. BOWER

Cultural values and the retarded child

Although some progress has been made in bringing the mentally retarded child into the consciousness of the community, values exist in our culture that, to the degree they are present in each individual, make progress in this area difficult. It is the purpose of this article to examine and analyze these cultural values so that they may be raised to a higher level of conscious awareness and thereby be acted upon with greater freedom.

It might be well to begin by explaining the meaning of the term "cultural values" as used in this paper. Cultural values are those values or ideals shared by most members of the culture *that act as directives or prescriptions for behavior.* The values by which a culture functions might be compared to the motives that underlie individual behavior. In both cases the values that act to direct the behavior of the individuals are to some degree unknown to the behaving unit. Values and motives also have compulsive and coercive aspects. Fromm suggests that cultural values "shape the energies of the members of society in such a way that their behavior is not a matter of conscious decision as to whether or not to follow the social pattern but one of wanting to act as they have to act and at the same time finding gratification in acting

Dr. Bower is consultant on mental hygiene and education of the mentally retarded for the California State Department of Education. He delivered this paper in Butte, Mont., in March 1956 during an institute on mental retardation sponsored by several state and federal agencies.

according to the requirements of the culture." [1]

Since cultural values are usually extrapolated from the behavior of members of the culture, they are at best inferences. Such inferences are usually made at a level of abstraction that may tend to narrow the wide range of differences in these values as held by individuals within the culture. For whatever cultural values do exist the ultimate reality of their existence rests in each individual and differs to the degree that his biological make-up, socialization and enculturation experiences have been different.

Two components of cultural values need to be reemphasized for the purposes of this discussion. First, cultural values as mediated by the individual often become behavioral imperatives, the sources of which are not known to the individual. Second, by assisting individuals to be cognizant of these sources and their directive nature in determining behavior one is also often able to assist them to re-perceive and reorganize the reality upon which new attitudes and feelings are based.

It is the purpose of the following exposition to pose several basic values or cultural themes and to show how these values might affect the lives of retarded children and persons who interact with them. Some emphasis will be placed on the child's educational problems both in the public school and in the home because it is felt that education provides the most visible and demonstrable examples of the operation of these cultural values. This discussion is not intended to raise moral or ethical questions about the nature of our cultural values. It is hypothesized, however, that a better understanding of some of the value systems in our culture as they affect persons who interact with the problem of mental retardation may help these individuals become freer and more responsive toward the mentally retarded child and his family.

The first value relevant to this problem might be stated thus: *Each individual is born free and equal; therefore he has equal opportunity with his fellows to be successful.*

Since each individual has the opportunity to succeed, the responsibility for a person's success or failure in life rests squarely on him. Those who do not succeed therefore cannot be regarded as being as good as, that is, as conscientious or diligent as, the successful.

The first effect of this value may manifest itself in the parents' perception of their child. Since many children are perceived as extensions of parental egos it may be extremely difficult for some parents to adequately assimilate the child's inabilities and disabilities. Some parents are able in time to deal with the disappointments and despair they feel about their child's learning ability; others may employ defense mechanisms such as rationalization and/or denial. These may take the form of outright rejection of the idea that the child's difficulties stem from mental retardation; or the retardation may be tentatively accepted but with the strong belief and hope that the child will outgrow his difficulties. Whatever adjustment the family has made for the first six years the advent of school attendance brings the child into an arena of activity where, as the saying goes, "he will sink or swim."

The retarded child who is physically not too different from other children his age poses the greatest problem when he starts to school. At that time he is launched into

[1] Erich Fromm, *The Sane Society*, New York, Rinehart & Co., 1955, 79.

the sea of words, numbers, pencils, books, report cards and a multitude of new interpersonal relationships. As he continues in the grades, such a child soon finds himself floundering in a tidal wave of symbolic and abstract concepts. Often he is coached and cajoled to apply himself and learn. When despite his efforts to please his teacher, his parents and himself he continues to fail, one cannot help but wonder whether he is *really* trying. For those who have little difficulty in being successful in school it is inconceivable that there are some who could not perform simple school tasks *if they tried hard enough*. The last resort for the child, the teacher and the parent is a special or ungraded class. However, this resource (when available) is often utilized with reluctance and guilt; resorting to it may be perceived by the administrator as the casting out of the child from the school society or by the parents as the final and convincing blow to their efforts and their egos.

A second relevant value or theme, related to the first, might be stated thus: *Success is accomplished by doing well those things defined by the experiences and values of those responsible for the appraisal of success.*

What are the realities of success in our culture and our schools as a retarded child faces them? To answer this one might look at the realities of success as defined by teachers and administrators in our society. Most are individuals with above-average intelligence who in their training read books, wrote papers, took notes, discussed concepts, competed for grades and succeeded in graduating. What was learned, in addition to subject matter and pedagogy, were the basic values and meaning of education, for it is in what one does in becoming educated that one defines the meaning and goals of education. It is understandable then that in the process of becoming educated those who have been successful in this endeavor may have unconsciously erected a set of values in which the experiences they have had are identified as education while other kinds of experiences, necessary though they may be in a democratic society, are not really education. Therefore while an individual may verbally acknowledge the need for special educational facilities for mentally retarded children it may be difficult for him to visualize what positive values accrue to either the teacher or the children in such programs. This is exemplified by such comments as "I guess someone has to do what Miss Brown (special class teacher) is doing but I don't really know what she can accomplish with them."

Theoretically a special class, small in size and under the direction of a specially trained teacher, has the elasticity necessary to adjust the learning experiences to the child. Where special classes are set up in regular elementary and secondary schools it is often difficult, however, for some communities and school staffs to be comfortable with the program. To place a child in such a class is often quite disconcerting to some parents and educators who feel that democratic ideals are being perverted by any type of special program. They reluctantly admit that the child is not learning in a regular class but feel guilty and dismayed to recommend an adjusted program. Usually abstractions with black-and-white implications such as "isolation," "segregation" and "undemocratic" are cast about as objections to such placement. It might be well to note that if special programs are "isolated" or "segregated" or "undemocratic" it is the perception and behavior of the majority of individuals in the school or community which creates the social climate of "isolation" or "segregation."

A third theme might be stated thus: *Success is measured by certain quantifiable variables.*

School success is most often evaluated by the use of grades, achievement test scores, the number of clubs one belongs to and the number of friends one has. There is little a retarded child or adolescent can do to excell in any of these measures of success. Once in a while such a child will achieve some success in athletics or other non-academic activity, but examples are rare. A child with a low IQ is not expected to be successful in the important skills promulgated by the school. Our culture places great value on sheer brains and intellect; indeed in a mobile society emphasizing achieved status intelligence is a critical tool. Its importance is magnified, however, when it is equated with virtue, health and happiness. Intelligence as a factor in personality development needs to be perceived in its proper role. As Kanner points out, popular fiction casts Mephistopheles as one with high intelligence and brilliant sophistication; Till Eulenspiegel, the *narr* or fool, is usually the likable, harmless individual. "Gradually intellectual achievement has been put on a pedestal," to quote Bovet, "in the same way as modern society worships money and material success. The re-establishment of a healthier hierarchy of mental values, wherein intelligence would once again take its proper place as a tool in the service of higher values, is a task which may be outside the province of mental health, yet is very directly concerned with it." [2]

A study by Buswell [3] illustrates the reciprocal relationship of intelligence, school success and a child's social acceptance as well as answers the chicken-egg questions on school success and school acceptance. Utilizing measures of intelligence, achievement and acceptability with kindergarten and 1st-grade children she found that "achievement," as a basic factor in acceptability, precedes rather than follows acceptability. She notes that "in kindergarten, before academic success is evident, the future achiever is not chosen in social relationships any more frequently than the future non-achiever. Early in the first grade, when a different kind of achievement than occurred in kindergarten is becoming evident, those who are successful in this achievement are also the socially most accepted. If the acceptability were responsible for this achievement, those who had been popular in the kindergarten the preceding spring should be the ones to succeed in school in the fall" (p. 51).

The problem of providing adequate and successful educational experiences for retarded children becomes especially critical at the high school and pre-vocational level. A retarded child with little skill or preparation and negatively oriented to school life can seldom be successful in the usual high school course of study. Programs of terminal vocational preparation are also unable to fit such children into their courses. This is owing in part to the fact that all faculties seek status and acceptability for their program in the high school; to be labeled as the most likely situation for retarded children does not seem to promote increased status in the eyes of faculty or students. In addition the high school has historically been a selective, college preparatory institution. Graduation from high school meant something. To ask a high school to accept, educate and graduate a mentally retarded child may elicit furrowed brows and more than mild consternation in the school and community. As part of the public school system the high school may be aware of its responsibility to all the children of all the people; as an institution with an historical

and academic tradition of selectivity and standards of achievement it usually defines "all the children" as those who are able to profit by the present program.

Often the effort to secure an appropriate educational program for retarded children at the high school level is resisted as being anti-intellectual and anti-democratic and in general as lowering the standards of high school education. The difficulty lies perhaps in the perception of education as being essentially one experience for all with gradations of difficulty, rather than programs based on real differences of intellect, purpose and interest. As Krugman puts it, "Obviously, the reasoning is that all adolescents must be forced into a single mold of classical education even if it means what it has always meant—their being squeezed out of school without an education. Presumably that would be democratic education. What is really being rejected is the application of the principle of individual differences as well as the recognition of individual needs within a complex changing society. By what reasoning a return to a secondary education program that eliminated 90% of the population can be considered more democratic than one that attempts to provide for all, I am at a loss to discover." [4]

A fourth value influencing our interaction with retarded children may be stated thus: *Real success is something that will be accomplished in the future.*

This value is manifest when we remind children that what they study in school may have no real value now but will be pretty important someday. For most this is acceptable; the resultant goal delay usually causes little reality difficulty. But for those whose problems center more critically on the present and who need help in solving problems of everyday living the goal delay serves only to increase tension and dissatiscation with present activities. The problems of mentally retarded children are centered in the here and now; the future is an unreal, nebulous concept. Education for the future serves only to make the entire concept of education more puzzling to them.

This orientation—schooling as preparation for the future—also serves to confuse teachers and parents of retarded children since it is often difficult to perceive a future for the child. Where attempts are made to assist the child with present-day problems and to offer practical help in the problems of present-day living it is often difficult, strangely enough, to develop an adequate curriculum. The aims of education may often be so set on preparing children for life that it may not be easy to perceive the necessities of living.

Lastly, as programs for retarded children have developed, resistances toward their full acceptance have manifest themselves in an equation which might be shown as:

Money and effort spent on retarded children	=	Money and effort spent on gifted children

There is no denying that children who are intellectually gifted or talented often need special help. There is no denying

---

[2] Lucien Bovet, "Psychiatric Aspects of Juvenile Delinquency," *Bulletin of the World Health Organization*, 1951, 52.

[3] Margaret M. Buswell, "The Relationship between the Social Structure of the Classroom and the Academic Success of the Pupils," *Journal of Experimental Education*, 22 (September 1953) 37–52.

[4] Morris Krugman, "Education's Debt to Orthopsychiatry," *American Journal of Orthopsychiatry*, 23 (July 1953), 453.

that money should be spent to develop potential physicists, chemists, social scientists and others. Such motivation and interest, however, should be based on the real needs of this group or these groups and should not be a product of social guilt or uneasiness about providing a program for mentally retarded children. The tendency to balance costs in terms of IQ distribution or any dimension other than the real needs of the child may lead to interesting implications. For example, should an extra expenditure of money to equalize educational opportunities for physically handicapped children be balanced by an expenditure for the more physically fit? Should programs be promoted for children with superior hearing ability or superior sight as a result of programs for deaf or partially seeing children? Relative values of worth, social or monetary, cannot be placed on human beings without risking democratic ideals and democratic practices. Helping retarded children and gifted children to educational programs that can result in economic efficiency and social adjustment may require understanding of the principle of the different *right* thing for everyone.

NATHAN S. KLINE, M.D.

Pharmaceuticals in the treatment of psychiatric patients

In one of our research laboratories where isotope studies are undertaken there is an instrument called a multiscaler capable of counting 500,000 electrical impulses a second. I have tried to think what 500,000 of anything per second would be like and find that it is simply incomprehensible to me. Greater familiarity with the machine and more thinking in this order of magnitude would probably reduce my amazement —but it is still most impressive to count that fast.

Similarly, the facts about mental disease may seem less startling after they have been repeated dozens of times but their immensity remains really staggering. There are over 700,000 patients in mental hospitals in the United States and the rate of admissions is increasing faster than the population. In New York State the first admission rate has approximately doubled in the last 50 years. Even now there are as many beds for mental hospital patients as for patients with all other diseases put together. It is estimated that if admissions continue to increase at the present rate one out of every 10 persons in the United States will spend part of his life as a patient in a mental hospital. In the Greater New York area this means that about 1,000,000 will be hospitalized. During World War II over 850,000 men were rejected by Selective Service for psychiatric defects. Forty-three percent of all army discharges were for neuro-psychiatric disorders.

As with the 500,000 count per second of

Dr. Kline, director of research at Rockland State Hospital, Orangeburg, N. Y., based this paper on a talk delivered in October 1954 at the College of Pharmacy during the Columbia University Bicentennial Celebration.

the multiscaler, these are figures that numb the imagination.

In dollars and cents, the cost is fantastic. Maintenance and treatment in mental hospitals require about $750,000,000 a year. Even then, in many places care is pitifully below the minimum really required. The recommended standards of the American Psychiatric Association would require billions. This does not include the waste—the loss of manpower, the dislocated homes, the human suffering. The strain on the individual taxpayer is illustrated by the fact that 28% of every tax dollar in the operating budget of New York State goes for the care of the mentally ill. If the cost of veterans' compensation is included, the total amounts to about $3,000,000 a day for the country as a whole. The loss to society is completely immeasurable.

Yet all this is only one facet of the problem because these institutionalized patients are almost exclusively psychotics—those whose sense of reality is seriously disturbed.

It is generally accepted that a third of all patients treated in ordinary medical practice have no organic illnesses. For another third, somatic disturbances are complicated by psychological factors. Add to these the neurotics under psychiatric treatment and the additional hundreds of thousands who are going to non-medical therapists. The combined total of psychotics and neurotics must run into the tens of millions.

To deal with this flood of patients there are a mere 8,000 psychiatrists plus the psychotherapists found among general practitioners and specialists in other fields. Until quite recently pharmacology had little to offer compared with other areas of medicine because words were still the commonest tools in the handling of the neurotic. This can be verified by the corner pharmacist as well as by the Park Avenue specialist. Some therapists became so enamored of words that they disdained to use the few drugs then available. Such an attitude is sometimes also ascribed to Freud. Yet he specifically stated that "the future will probably attribute far greater importance to psychoanalysis as the science of the unconscious than as a therapeutic procedure." Elsewhere he says, "Behind every psychiatrist stands the man with the syringe." There is reason to believe that medications with which to fill the syringe are now becoming available.

Before discussing these medications, let us briefly review the past role of pharmaceuticals in the treatment of psychological disorders. The most common symptom of psychogenic origin is probably the headache and to it the pharmaceutical industry has responded most handsomely. Among the various preparations available, it is aspirin that has achieved outstanding fame. William Saroyan even has a story about aspirin.[1] He says in part, "It *is* helping to keep people going to work. . . . It *is* sending millions of half-dead people to their jobs. . . . It *is* deadening pain everywhere. It isn't preventing anything, but it is deadening pain." The size of the American headache can be estimated from the fact that last year the production of aspirin in the United States amounted to 14,000,000 pounds. This was more than enough for every man and woman over 15 to have a tablet every single day of the year and two on Sunday.

The other great group of drugs for psychological use has been barbiturates. Production of these amounted to some 600,000 pounds in 1953. Part of this is for use in the treatment of epilepsy but most is for general sedation or sleeping pills. It is non-

[1] Saroyan, William, "Aspirin Is a Member of the N.R.A.," *The Daring Young Man on the Flying Trapese*, New York, Random House, 1934.

sense to talk as some have about reducing production of the barbiturates to control their use. Man should not be deprived of this valuable weapon. These drugs meet an important need, and until the need no longer exists or until a better substitute is found they should serve to alleviate human suffering. As to the problems of addiction: If it weren't the barbiturates it would probably be something even more toxic, such as amphetamine, which claims a million addicts in Japan.

There exists one other great class of drugs that is not usually considered as belonging to the group used in treating psychological disorders. These are the vitamins. With the increase in size of the older age groups they have become increasingly important. Their use as a specific in the treatment of patients with cerebral arteriosclerosis and senile dementia will be touched on later. Not only will severe avitaminosis produce psychosis but milder degrees of vitamin deficiency can simulate many of the neurotic syndromes. Of course, many individuals hypervitaminate themselves but so far as we know it is a relatively harmless kind of addiction.

In the therapy of specific psychiatric diseases there have been two great advances. The first is reflected in admissions to mental hospitals for syphilis of the central nervous system. In 1933 the admission rate was 7.9 per 100,000. Twenty years later, in 1953, the rate was less than 1.7 per 100,000. From 9.0% of all admissions there are now fewer than 1.5 admissions for this condition in every 100. The role of penicillin cannot be precisely evaluated but it is unquestionably one of the major factors in the dramatic curtailment of this once devastating disease. There is the great likelihood that because of pharmaceutical progress within another few generations syphilitic paresis will be a disease of the past. The cost of treatment has been so reduced that one authority now says "it is cheaper to cure syphilis than to catch it."

The second major advance has been in the treatment of the epileptic. Since the introduction of the hydantoins (dilantin and mesantoin) and other anti-convulsants the admission rate to Craig Colony, the New York State epileptic institution, has been only a third of what it was 20 years ago. It is worth pointing out that the hypnotic, sedative and anti-convulsant effects of these drugs were once thought to be inseparable. It was when the anti-convulsant effect was shown to be independent that the full pharmacological benefit became possible. Now that it seems definite that a sedative effect can also be produced without inducing sleep we seem to be on the verge of another great advance in the treatment of psychological conditions.

The introduction of the analeptics for the treatment of depression has helped to relieve one of the saddest of psychiatric conditions. Electric shock therapy is still the major instrument of treatment but there are indications that new stimulants currently being tested may eventually replace shock in the therapy of depression. The ability of such compounds as desoxyephedrine and amphetamine to stimulate has become general knowledge and preliminary trials with iproniazid seem to offer a promising approach to the treatment of withdrawn, seclusive, depressed individuals both in and out of the hospital.

Finally, the endocrine preparations have played an important role in psychiatric treatment. In addition to replacement therapy such as the use of thyroid extract in myxedema and sex hormones in postmenopausal depression, the important role of insulin in the treatment of schizophrenia should not be forgotten. Until the present

new drugs were introduced it was the most effective weapon we had against schizophrenia. Despite this, the admission rate for this disease continued to increase out of proportion so that in New York State in 1953 it was three times as great as in 1909.

The value of these medications should not be underrated but they barely touch the surface of the problem of disease of a psychiatric nature. Progress in the treatment of infectious diseases has extended life many years; the development of the sulfa drugs and antibiotics has contributed to this. It is paradoxical that this advance in the development of pharmaceuticals has inadvertently led to an increase in the number of psychiatric patients. There has been an increase in first admissions over 70 in the last 20 years. In 1930 they constituted 12% of all first admissions; in 1953 they constituted 30%. This increase in age is paralleled by an increase in the admission rate of patients with senile dementia and cerebral arteriosclerosis. The rate in 1912 was 2.0 per 100,000 of population and in 1953 had increased more than tenfold.

Any discussion of current research is necessarily limited by the knowledge of the author since frequently the most exciting projects are not yet ready for print. Our early work on oral preparation of the whole root of Rauwolfia serpentina and reserpine (an alkaloid of Rauwolfia serpentina) convinced us of its effectiveness as a sedative. Experience with massive doses of the intramuscular preparation has equally convinced us that it is *more* than a mere sedative. In one of our early experiments 150 of the most disturbed patients who were on so-called "maintenance electric shock"—to reduce the danger of their hurting themselves or other people—were given reserpine. Originally the intention was to determine if reserpine would "hold" the patients as well as shock therapy did, since they had extremely poor prognoses and the most we had expected was to make life more comfortable for them and others in the hospital. To our surprise not only was reserpine as good as or better than shock but we found that about 22% of the patients who received it were able to leave the hospital. We then discontinued medication to determine if their improvement could be maintained without further treatment. We now know that continued oral medication is needed in some cases but not in others. Even when it is needed the cost is minute compared with the $1,200 which the State of New York spends to maintain a single patient for a year.

The gain in humanitarian terms is immeasurable. That has been confirmed by other researches on different types of patients elsewhere in Rockland State Hospital. In the case of the most disturbed patients referred to previously, Dr. Joseph Barsa found that in the year prior to drug therapies less than 5% of the patients were discharged but in the first year of drug therapy, with only a segment of his patients under this treatment, more than 15% were released.

In the three and a half years since the presentation on which this paper is based there has been dramatic confirmation of the original predictions. In 1955, the first year of any extended application of the drugs, there was a slowing down of the rate of accumulation of patients in mental hospitals. Last year, for the first time in the almost 200-year history of public mental hospitals in the United States, there was not the expected increase of 10,000 to 12,000 patients but a decrease of over 7,000 patients—a difference of almost 20,000 patients. Since the major change in treatment during this period was the introduction of reserpine and chlorpromazine it is

difficult to believe that these were not the most important single factor.

In the original presentation it was predicted that these drugs would provide valuable clues for research. Current work with serotonin and related compounds and the effect of these drugs on the nervous system have opened whole new areas of investigation.

The use of reserpine as a sedative in the treatment of neurotics was also referred to in the original presentation and the conjecture offered that sedation need not always be accompanied by a sleep-producing (hypnotic) effect. At the Columbia University Bicentennial Celebration the statement was made that "it would be a fair guess that within a few years the sedative use of barbiturates will be markedly reduced." Two of the major pharmaceutical houses, using 1953 as a base line, report that their sales dropped to 82% or 83% in 1954, to less than 70% in 1955 and to 51% in 1956.

The expectation that new compounds of this type would be developed has exceeded the wildest expectations. A number of these are already on the market and dozens more are in the test stage. Last year the sale of these drugs exceeded $200,000,000 and 35,000,000 prescriptions (a third of all prescriptions) were written. The pharmaceutical industry is throwing its vast resources into the fight against mental illness.

In the field of anti-convulsants and analeptics, drugs are currently being evaluated which hold the promise of being more effective and less productive of side-effects than those currently available. For the 500,000 to 750,000 epileptics in the United States additions to the barbiturates, such as the hydantoins (dilantin and mesantoin), the oxazolidine-2, 4 diones (tridione and paradione) and the acetylureas (phenurons) are of great importance. Several very promising new preparations are currently in use in various places. Evidence that glutamine is capable of reversing abnormal E.E.G.'s is of tremendous significance since it may indicate that in certain epileptics a deficiency of this substance produces the disease.

Glutamic acid, histamine and nicotinic acid, metrazol (nikethamide) and other preparations seem to be of some value in the treatment of arteriosclerotic and senile conditions. One of the greatest difficulties in handling this group of patients is the fact that their sleep rhythm becomes disturbed. As a result they wander about at night in a confused state and are apt to cause difficulties for themselves and others. Unfortunately the barbiturates frequently seem only to increase the confusion without helping the patient get the necessary sleep. With adequate sleep many of these patients would improve in other respects; at least a percentage of them would not have to be hospitalized. We are currently testing preparations that appear most useful in this respect.

The more than 100,000 mentally deficient in institutions may also be aided by some of the studies on brain metabolism currently in progress. Some of the most outstanding scientists are turning to this problem with really adequate support for their research.

The 4,000,000 problem drinkers—including the 1,000,000 chronic alcoholics—account for an increasing number of admissions to mental hospitals. Adrenocorticotropic hormone (ACTH), chlorpromazine and reserpine have proved effective in delirium tremens, and in some cases adrenocortico extract has enabled the patient to remain off alcohol.

Acetylmethadol has been found useful in the management of morphine addiction and is particularly convenient since it can be given orally. Another preparation, N-allyenormorphine, enables quick determination

of whether a person is physiologically addicted to opiates. Both chlorpromazine and reserpine have been reported of help in lessening the agonies of withdrawal.

Evidence continues to accumulate that in schizophrenic patients the endocrine glands do not function in a normal fashion. Along with the mounting evidence of adrenal disorder, a number of investigators have demonstrated a similar thyroid disorder by the use of radioactive iodine. Response of the antidiuretic hormones to stress provides another clue. Whether these disorders are causative still remains to be seen, but a whole endocrinological-pharmaceutical approach has been initiated. There is also evidence of disturbance of brain enzymes (the tricarboxylic acid cycle) and disturbances of tryptophane metabolism in schizophrenics.

Much speculation has been aroused by the ability of LSD (lysergic acid), mescaline and other substances to produce schizophrenic-like symptoms. It has been postulated that in the schizophrenic patient defects of metabolism may lead to the production of these substances instead of related-but-normal products. The ability of serotonin to neutralize some of these in other circumstances suggests the possibility of a method of therapeutically testing this theory.

I cannot resist emphasizing the tremendous problem of financing research in mental disease. New York, although it has a farsighted commissioner of mental hygiene and an understanding legislature, needs a more adequate budget for research. Despite the fact that over half the country's hospital beds are for psychiatric patients less than 5% of the funds spent for medical research are devoted to research on mental illness. Of the $500,000,000 spent by state governments for the mentally ill less than 1% goes for research. In contrast, the pharmaceutical industry spends from 4% to 12% of its gross income for research; an average of 6% for the industry calls for a yearly expenditure of roughly $60,000,000. In developing reserpine one of the companies spent over $1,000,000 in less than a year. Without this tremendous investment in future possibilities, drugs with the efficiency of those described above would not be available. On the average only one out of every 400 new preparations reaches the market and this one requires about four years of development. When the customer pays for his medication he is buying not only relief for his present ills but future treatment for diseases that are incurable today. The increased interest of the pharmaceutical industry in drugs for mental disease will provide new life blood, not only in the form of more adequate financing but in the fact that there will be more trained scientific personnel concentrating on these problems.

There is today the feeling that we are on the verge of momentous, dramatic discoveries. An older brother, a research pathologist, once chided me for going into research in such an uncertain field as mental disease. "Doing research in psychiatry," he wrote me, "is like playing poker with the deuces wild." But it is this very factor of chance—chance that the cards we are now being dealt may fall into some unexpectedly happy combination—that held many of us fascinated through the lean years which *deo volente* are now ending.

MORTON LEVITT, PH.D.
BEN O. RUBENSTEIN, M.S.W.

The fate of advice: examples of distortion in parental counseling

The tremendous growth of the mental hygiene movement in the last twenty years has resulted in the wide dissemination of psychological advice to the general public. University classes, adult education programs, parent-teacher meetings and child-study groups have all made positive contributions to this end. Inherent has been the belief that parents who have been exposed to mental hygiene principles would become more effective and more secure in the educational handling of their children.[1] That the state of affairs described above has proved something of a mixed blessing could be seen as far back as 1946 when an editorial (1) in the *Child Study Quarterly* as well as articles by Stone (2) and Gruenberg (3) in the same periodical called attention to the fact that emphasis upon "problem parents" was proving an onerous burden to parents in general. More recently such perceptive observers of the contemporary psychological scene as Spock and Bruche have taken a similar position. It should be recalled, however, that Freud in two articles (4) written as early as 1907 and 1908 suggested exerting some caution in efforts to accomplish educational tasks, warning specifically against "the unwisdom of putting new wine into old bottles."

This paper concerns itself with the fate of advice given to parents whose children are in treatment. The forced intimacy of the therapeutic task makes for close relationships with parents and the need for frequent consultation leads to efforts to make parents literally "partners" in treatment by offering educational suggestions.

Dr. Levitt and Mr. Rubenstein are members of the faculty of Wayne University College of Medicine.

[1] A paper by M. L. Falick, M. Peters, M. Levitt and Ben Rubenstein entitled "Some Observations on the Psychological Education of Teachers" in the July 1954 issue of *Mental Hygiene* discussed related problems in the education of teachers.

Observation of the fact that some parents could do little with such advice brought the present authors to the realization that unconscious elements in the personality structures of parents often cause the distortion, nullification and even on occasion the reversal of well-intended advice. It is important to be aware that the treatment relationship between therapist, child and family provides a unique opportunity to observe the vicissitudes of advice, for the child analyst has a three-sided observation booth, as it were, speaking to and hearing from the child as well as each parent.

In the four brief case studies that follow efforts will be made to indicate what advice was given and what actually was its fate in the exchange between parent and child.

Sam, a 9-year-old, had been completely toilet-trained by the age of 3. Shortly after the birth of another child, training broke down and Sam wet nightly from then on and also began occasional soiling episodes. Interviews with his parents established the fact that they had never made the patient consciously aware that they disapproved of his defections. Sam's reality, as he saw it, provided *carte blanche* for symptom continuation; he exploited this fact defensively in treatment. Since a continuation of the *status quo* at home threatened therapeutic success his parents were advised to express some irritation and annoyance regarding his problems. The parents agreed, with some reluctance, to try to be firm with Sam. Results were forthcoming immediately. Sam came to his next appointment in full resistance and threatened never to come again. What had happened? His father had told him that he would now have to be treated more firmly because the therapist had so directed.

Ted, an 8-year-old, was placed in treatment because of uncontrolled behavior. His father's interest in the process could be characterized as a "tell-us-what-to-do" attitude. He invited the therapist to come into the home in order to do a "time study" of the family to "reorganize" the household along more "economic lines." (All quotes are the father's exact expressions.) His persistent demands for advice led to a cautious suggestion that he try to spend a little more time with his son under pleasant circumstances. In this endeavor the father took his son to the family business, a tool shop, and assigned him impossible tasks such as cleaning expensive tools with kerosene. When Ted broke some of the tools and fled the father spent several hours looking for him and then called the therapist to report how poorly treatment was going.

Gary's mother complained of his stealing money and candy, of his tantrums and his refusal to eat. She pleaded for help with her 6-year-old son. The suggestion that she pay less attention to the eating problem and avoid open exposure of money and candy brought no relief. The unhappy mother continued to complain that the suggestions were of no avail and attempted to enlist the therapist's aid in detecting the whereabouts of the loot. When it was pointed out to her that she was nullifying the suggestions she could only describe her impotent rage at Gary's denial of ownership of the stolen money and candy in his drawer. She concluded by saying that she would be satisfied with nothing but a complete confession of his guilt.

Stuart, an 8-year-old soiler, had revealed during treatment his unqualified belief in the omnipotence of women. His intelligent, smiling, cooperative mother carried the complete burden of the treatment plan, his father being resistive and threatened. At one point when Stuart became difficult to manage in the home the mother asked for help. It was suggested that her husband

assume the responsibility for discipline. She returned with a smile but indicated failure of the plan, for Stuart persisted in behavior which required his physical removal from the scene when the father was not present. She was then advised to tell Stuart that she could not physically control him but would report his behavior to his father. The now unsmiling mother responded vehemently that she could never accept the implication that women were in any way inferior to men. It was apparent that this woman could neither involve her husband in discipline nor depreciate her own power in the eyes of her son.

DISCUSSION

Gary's and Ted's circumstances bear certain familial similarities. The parents of these children are characteristic of a group who are persistent in their pleas for advice and yet are unable to utilize it when it is offered. They admit the failure of their own methods and are seemingly desperate in their need for help. "Tell us what to do" is their cry. Our relationship with them, however, convinces us that our advice will be gratuitous. The probability exists that the desperation of these parents is based upon an unconscious awareness that they are forced to support the child's symptoms because these represent their own unresolved conflicts. We feel that in those instances where attempts are made to alter the balance of psychic forces between parent and child the parent is compelled to regress and to reestablish the original neurotic involvement with the child. It appears that the child responds to parental regression and the resultant behavior of the child provides the parent with the opportunity to righteously vent his feelings in defensive fashion against the representation of his own conflicts. As this circular current mounts in intensity so does the unconscious guilt of the parent. It is at this time that he asks for help but if we understand him clearly he is saying, "I want you to relieve my guilt." Concurrent with this is the unconscious hope that the advice will inevitably fail. Psychic economy is thus maintained by the thought, "The expert has failed; therefore I cannot be so bad." The initial unquestioning acceptance of advice is now clear, for the complete confidence in the therapist prepares the way for the pre-ordained hostility when the advice, by necessity, fails. The connections between self-perpetuating conflict and pre-verbal symbiosis is most marked in those instances where the child is inordinately sensitive to the parents' unconscious. The child responds to the parents' repressed wishes but immediately becomes the victim of their defensive reaction. By the same token the therapist's activities fall into the identical orbit. Suggestions that aim to free the child must be denied. The correctness of the above formulation can be verified in part by the poorly concealed eagerness of Gary's mother to enlist the therapist as an ally in her desperate effort to stamp out every vestige of disguised impulse-expression as objectified in her child by the stealing of money and candy.

The fate of advice in the instance of Stuart, whose mother could not tell him that women were weaker than men, reveals another concatenation of psychic forces. We are here dealing with the mother's unconscious denial of the anatomical distinction between the sexes. Her defensive reaction was of such intensity that her son's masculinity hung in the balance. The mother was cooperative and positive in her wish to aid her son against all odds. All suggestions were completely acceptable and were carried out until they ran counter to her own specific difficulty. Considerable ex-

perience and sensitivity are required to correctly assess such situations. Earlier perception of this mother's phallic aspirations could have forewarned us that any advice designed to restore Stuart's masculinity would activate the kernel of her own neurotic conflict.

Sam's parents, who were completely accepting of his problems, are typical of another group. These are the parents who have drawn considerable intellectual support from their specialized interest in the permissive aspects of mental hygiene literature. Great strength underlies the apparent passive acceptance of Sam's symptoms by his parents. We feel that their support can be explained by the need to maintain a positive relationship with their child. For such parents, to be negative, firm or aggressive has a specific ontogenetic meaning. Sam's mother had been enuretic until the onset of menstruation; Sam's father had reacted strongly to his own father's punitive handling of an older brother who wet his bed. Here again we find parents identified with the child's symptoms but the defensive alignment differs from that in the previous example. Sam represented a truly emasculated child for he wet and soiled at age 9. The resulting guilt of the parents was the touchstone of their resistance. They felt unconsciously responsible for the child's disorder and therefore could not be firm. We would suspect that there are strong elements standing in the way of identification with their own parents. In this sense the therapist may well represent a bad father in the minds of such parents.

CONCLUSIONS

1. Advice that runs counter to the unconscious defenses of parents and that threatens their own psychological adjustment is likely to be rejected.

2. Such advice must be defended against because it threatens the neurotically-continuing nature of the symbiotic attachment between child and parents.

3. The peculiar significance of symptoms to parents often precludes the giving of any advice until the therapist is aware of the unconscious meaning of the child to each parent.

REFERENCES

1. Anna W. M. Wolf, "Problem Parents," *Child Study*, 24 (Winter, 1946–47), 35.

2. L. Joseph Stone, "The Earliest Years," *Child Study*, 24 (Winter, 1946–47), 38.

3. Sidonie Matsner Gruenberg, "The Modern Mother's Dilemma," *Child Study*, 24 (Summer-Fall, 1947), 100–103.

4. Sigmund Freud, "The Sexual Enlightenment of Children" and "On the Sexual Theories of Children," *Collected Papers*, Vol. 2, London, Hogarth Press, 1948.

JULES V. COLEMAN, M.D.

Motivations of the volunteer in the health and welfare fields

There have been many studies in motivation, but curiously its application to the volunteers in the health and welfare fields has received very little attention. Most studies in motivation are centered around what are apparently regarded as more practical problems or at least around problems with greater practical urgency. It is as if volunteering in the fields of social welfare and health is a matter of only secondary importance. If it does at times engage the interest and participation of people with outstanding endowment, it seems to do so for reasons which are removed from the content of the field itself. To some extent, this is understandable enough. For example, a member of an agency board who has himself no professional knowledge of the work of the agency can hardly be expected to make a professional contribution. And nobody expects him to do so, except then there often remains the problem as to just what *is* expected of him.

It seems to me important to stress this matter at the outset for reasons which I think can readily be made clear. There are innumerable definitions of motivation but they all stress its quality of emotional impulsion associated with emotionally important goals. McClelland,[1] for example, defines a motive as "a strong affective association, characterized by an anticipatory goal reaction and based on past association of certain cues with pleasure and pain." Rainer Fuchs[2] puts this somewhat differently and perhaps more concretely when he says: "What matters is the *conviction* of reality of a factual and meaningful connection between content and emotion." Studies in motivation have been conspicuous in such fields as education, particularly in relation

Dr. Coleman, a faculty member in the department of psychiatry at Yale University School of Medicine, presented this paper in St. Louis May 22, 1956 at the National Conference of Social Work.

[1] David C. McClelland, *Studies in Motivation,* New York, Appleton-Century-Crofts, 1955, p. 226.

[2] *Ibid.,* p. 29.

to learning theory, in psychotherapy and counseling, and in industry. All investigations stress the following as important components: how people feel about themselves, how they feel towards other people (especially as their interpersonal relations affect their self-feelings) and how they envision their social role. If these are important components in determining whether people volunteer in our own field of interest, it must be quite apparent that we know next to nothing about their specifics.

Let me return a moment to our typical agency board member, whom we left so recently in so sad a plight. We may leave aside for the present why he has agreed to serve on the board and consider how he might be able to visualize his role. He has presumably been invited to join the board because his name carries some importance to the community on which the agency depends, although his prestige will probably rest on activities in fields other than those in which the agency is interested. We can assume that he knows nothing about social work, let us say, or psychiatry, or hospital management. He himself will think of his responsibility as being in some way connected with representing the public interest. Under favorable circumstance he will consider his main job to be the extrapolation of the work of the particular agency into the broader picture of supportive and restorative responsibilities of the community to all persons in need of this kind of service. Under less favorable circumstances he will find his activities narrowed down to a defense of the function of an agency about whose philosophy he may have little understanding, especially as it relates to professional developments in the field as a whole. What he finds himself defending may be completely valid or completely invalid, and there is small likelihood that he will have either the equipment or the desire to make an objective judgment based on the merits of the case. In other words, he will rapidly find his loyalties so thoroughly engaged as to allow little room for the exercise of the more objective intellectual faculties.

To understand how our distinguished citizen, who has been conspicuously successful in his own field, may come a cropper in his volunteer activity, we might take a closer look at what motivates people in general. Emotional needs have been described in any of a number of ways, depending on the professional language of the particular discipline of the investigator. In general, the following needs are usually identified:

1. People need to feel close to others and to be able to give and receive affection. This need is usually reserved for the small group of family or close friends.

2. People need to feel secure, *i.e.* they need to feel they can trust their relations to other people to support them in and out of periods of crises, present or future.

3. People need to feel respect for themselves and a sense of enjoying the respect of others. This is the sense of self-esteem.

In other words, they need opportunities for dependency and dominance, for status and prestige, for approval and independence, for the release of emotion through either libidinal or aggressive channels and for the limitations which will control these releases in the interest of impulse stabilization.

We can describe these needs in another way which might perhaps bring them closer to our subject. We can say, for example, that people need to achieve the satisfactions of group participation and mean thereby that they need to feel part of the larger purposes and meanings of group life, to achieve satisfactions of dependency, affection, status and creative realization.

For some people group belonging offers the opportunity for the exercise of leadership potential, which provides special outlets of dominance, aggression and narcissism as well as of the special talents of the leader, *i.e.,* his capacity for imaginative projection, his tolerance of ambivalence and his ability to utilize it for creative group purposes, his capacity for identification with group needs and so on. Finally I think one might say that people are motivated to action whenever they run across a threat to their self-interests, *i.e.,* if they are able to identify the threat. For example, a protective neighborhood association may spring up overnight when a city government announces plans to locate a new high school in a choice residential section. The influence of self-interest is also very clear in the voting trends of people, particularly as they are affected by social class position and ethnic group membership.

To return once more to our board member (we might call him Mr. Smith so that he won't be quite so anonymous): He has joined the hospital board as one of the select few who have arrived at an elite position in the community. Not long ago he became a member of the board of the large local bank. As a community leader he recognizes and accepts a responsibility to participate in many civic activities which contribute to the social welfare and cultural advancement of his community. His life is shaped by these activities and by the people with whom he is now associated. His special training allows him to be a valuable bank director, but what training does he bring to the direction of a hospital (except, of course, his knowledge of financial and personnel problems, which we can put aside as being not unimportant but not relevant to our particular problem)? He need not be a business man, of course; he may be a lawyer or a physician, an educator or a labor leader, or a member of one of the community's old families who have always served on the hospital board. Whatever his social or professional background, his dilemma is the same: How is he going to define his function as a volunteer community worker?

It may be a little unfair to pick this kind of example. Certainly the problem is very much simpler in the case of the member of the woman's auxiliary of the hospital who volunteers to give six hours a week to helping out in the hospital coffee shop, which raises money for special needs in the hospital. If there is a problem in volunteering for community service, however, it is more likely to be in areas which are less well-defined. I may remind you of the statement I quoted before, by Fuchs: "What matters is the *conviction* of the reality of a factual and meaningful connection between content and emotion." I might put it this way: What matters to Mr. Smith when he first joins the hospital board is that he has achieved a greatly desired token of social approval and of special group belonging. But once he has joined the board it will be important to Mr. Smith, and particularly to the community as a whole, that he have the chance to develop a deep-seated conviction that there is a "factual and meaningful connection" between the emotional and social satisfactions he derives from belonging to the board and the real value of his activities in relation to the public function of the hospital.

The problem is possibly even more complicated, because it is even less clearly defined, in the case of membership in agencies with primarily educational or fund-raising functions. Here I shall use the mental health association as my example, although you will all be aware of others with similar problems. Mental health presents a problem in a class by itself in that it is con-

cerned with an illness that is hard to characterize through the use of slogans and that is also hard for the layman to understand in all its ramifications. (Incidentally, the same kind of problem arises in connection with the work of a family agency.) The nature of the problems dealt with is difficult to conceptualize and to reduce to categories that engage the imagination of those without professional training. Furthermore, although almost everyone has someone in his family with serious emotional problems, reactions to emotional illness are so colored by guilt, denial, rationalization and rejection as to restrict seriously the possibility of meaningful identification with real aspects of the problem. To be able to identify in this way the emotional problems of others, one has to be able to accept one's own without defensive screening, a formidable task indeed.

I have emphasized throughout that volunteering must find a counterpart for its emotional motivations in a real and meaningful relationship to the content of the agency's function. The dilemma of the volunteer in a professional agency is that there is little likelihood of his having any real understanding of the work of the agency. The dilemma of the volunteer in a citizens' agency, such as a mental health association, is that he has little likelihood of understanding the nature of the field, and in mental health will experience emotional barriers blocking his identification with the real problems of the field.

Agency executives have tried to meet these difficulties in various ways. Perhaps the most common is the educational program designed to provide volunteers with information about the work of the agency and about the nature of the problems in the field. This is at best a relatively unrewarding task; it does not substitute for professional knowledge although it may provide a common meeting ground between laymen and professional, which facilitates the former's sense of belonging by sharing in professional problems. It remains on an unreal basis. It tends to have the effect of stimulating emotional engagement without providing suitable intellectual content to the role of volunteer.

Actually, if Mr. Smith receives a course of orientation to his new job as a director of the hospital it will be to the function of the hospital and not to his role as director. It is taken for granted that he knows what his role is supposed to be and that he will need to learn only those matters which involve policy decisions of the board. This all seems clear and relatively simple. Mr. Smith establishes an institutional identification with the hospital and its operational problems; he becomes an arm of executive function and completely dependent on the executive for guidance on matters of policy.

It was Clemenceau who said that war was too important to be left to the generals. This distinction between the technical expert and the politician may be useful in comparing the roles of the professional worker and the volunteer. If the volunteer has any function which is his own, aside from or in addition to his job as agency factotum, then it is to represent the public interest, to stand for the needs of the community and not only the needs of the agency. It may be of course that the needs of the one will coincide with the needs of the other. So much the better. But what if the agency has outlived its usefulness? Or what if changing community needs call for radical reorientation of a traditionally prized function? Where then does Mr. Smith's loyalty lie? And where will he have acquired the discipline of thinking which will help him to know his proper position?

In all of this I have been discussing the

problem that the volunteer encounters in trying to establish a connection between the emotional satisfactions of his volunteering and its significant community function. This is the problem that I suggested at the outset has received little or no study. I would like to suggest a methodology which might throw some light on the matter. When we ask ourselves why people volunteer for any particular community activity we tend to experience a feeling of helplessness, not only in recognition of the complexity of the question but also of its personal nature. Not all volunteers are interested in having their motivations studied unless of course they seem fairly obvious, as in the case of the lately burgeoning organizations working in behalf of mentally retarded children. However, even when the volunteer does not have a personal interest of this kind, he will often tend to think of his motivations, obscure though they may be, as not necessarily something that he would care to expose to the critical eyes of an investigator. He may not be sure what his motivations are, but he often has the uneasy feeling that they may not be suitable for public exposure.

However, if we shift our attention from the more personal, more emotional aspects of volunteering to the reality content to which it needs to be related we are immediately on safer ground. I think that a good many people would be willing to engage in discussions of this kind and that with this focus maintained they would also be interested in exploring the connection between personal and ideational motivation. Our method then would be to set up small discussion groups of volunteers, let us say in a local mental health association, with a trained discussion leader acting at one and the same time as participant-observer and investigator.

In studying a problem of this kind it is not enough to explore only the emotional gratifications of the activity or only its content. What is important is to try to understand how the individual acquires his "conviction of the factual and meaningful connection" between the two, what obstacles he meets in the process and what efforts he makes to overcome them, under what circumstances such a conviction may be established and when it is subjected to a sense of frustration or failure. If we define the problem in this way and conduct our discussion groups in an atmosphere of free inquiry, we may acquire a great deal of understanding of how the volunteer himself conceives of his activity, his motivations and his relation to the organization with which he has identified himself.

When I suggest that the volunteer has a broad public function I am in effect proposing a hypothesis which needs further testing and which might be tested by the group discussion method of observation. It seems to me that the role of the volunteer tends to be superimposed by agency executives; I am not offering a different role to be imposed in a different way. It should be possible for the volunteer to find his own definition of role, and the group discussion method offers him this possibility.

I am assuming then that whatever his personal and social motivations the volunteer in this field is also seeking an opportunity to fulfill a need for a special kind of public service that will provide outlets for impulses of dedicated activity in devotion to humanitarian purposes. The realization of such impulses can be satisfactorily achieved only through defined channels of activity based upon the volunteer's awareness and acceptance of his social role and its relation to the content of function of the agency he serves.

STEPHEN FLECK, M.D.

Recognition and utilization of the motivation of volunteers

Dr. Jules V. Coleman has discussed some general aspects of motivation, choosing examples from the health and welfare field. He further indicated that motivation for volunteer work is not, or at least is not known to be, essentially different from motivational forces that lead to activities not categorized as voluntary. There also appears to be no difference in the inner workings of our personalities that lead to action, whether the action is called professional or lay, whether or not it is socially useful (in which case we call it productive), whether the reward is tangible in the form of a salary or intangible in the form of prestige gain, whether the reward is immediate or so far in the future that it is neither tangible nor assured.

The dictionary defines a volunteer as a person who undertakes an activity or enters a service upon his own free will. I do not wish to philosophize about what this distinguishing "free will" is, whether it exists or not. So far as we have been able to study mammalian behavior, the human free will has remained elusive, but it has become evident that activity or action arises from constellations of socio-psychobiological forces that can best be understood within the framework of a stimulus-reaction system or a need-reward system of varying complexities and time relationships. Let me quote Robert Waelder, who addressed himself to this question of free will when discussing the difference between attitudes in social relationships and therapeutic or pedagogical attitudes: "The difference," he said, "amounts to this—that in the former—social—we treat our fellow man *as if* he were completely free. We make demands, appraise and condemn. As pedagogues and therapists we treat the other party—or more correctly the object of our pedagogical and therapeutic activity—as one who is not free, or to be more precise as if his freedom were limited."

As scientists we would also be less than

Dr. Fleck, who is associate professor of psychiatry and public health at Yale University School of Medicine and medical director of the Yale Psychiatric Institute, presented this paper May 22, 1956 in St. Louis at the annual meeting of the National Conference of Social Work.

precise if we failed to recognize that any activity—productive or unproductive, professional or volunteer, approved or criminal—is the result of choices and determining forces which permit the characterization of free will only if one foregoes any but the most superficial and casual observations of pertinent factors. It seems therefore more consistent with the scientific facts and with actual practice to consider, as suggested by Irene Malamud of Boston, that a volunteer is any person who works towards a goal—a goal such as community service—beyond his regular job and without pay. This, of course, bypasses the question of motivation, but it also makes clear that the distinction between volunteers and professionals—the lay board and the medical advisory board—does not really exist or at least should not exist. We so-called professionals are or ought to be just as much involved in so-called volunteer work as the banker or lawyer who might devote effort and energy to community health matters. Actually only the distance from one's own field makes for this artificial distinction of volunteer *versus* professional, and I believe the quicker Mrs. Malamud's pragmatic concept gains acceptance the better because, as we shall see, all the enterprises in which we are interested require the widest possible community participation *by* volunteers, *i.e.*, efforts from all of us beyond and after regular working hours.

Thus I believe I have laid the groundwork for dismissing "recognition of motivation" as a real problem because, as Dr. Coleman pointed out, motivation towards group identification and group or community participation exists everywhere and in practically everybody, at least in western societies. This leaves us with the more difficult considerations of how to mobilize and utilize such good will and drive for community enterprise.

Everybody knows examples of communities or segments of communities where apathy, self-neglect, even dilapidation, offer no proof whatsoever of any extant interest, let alone motivation, towards group welfare activity. But probably all of us also know of such conditions which changed almost overnight, sparked by a sudden or gradual re-awakening of community spirit, of group morale, of a wholesome pride in one's nest. It matters not whether such reversals occur in government, overthrowing a long-entrenched and corrupt group (as happened a few years ago in a large eastern city), bringing in a reform government to carry out the people's mandate, implementing individual and group motivation for a better community; whether a similar ballot expression brings into power a mayor with unique leadership gifts (as happened in New York City twenty years ago); whether leadership and organization for community improvements arise apart from elections or outside government channels. I say advisedly that there is no difference between these two types of organizations from the standpoint of community motivation and morale, and I shall return to this point later. I mention it here because we have to consider next another problem—diversification of community effort.

Obviously there are activities which, properly or traditionally, wisely or unwisely, are Caesar's, and there are others which are either left to or preempted with equally jealous zeal by non-governmental agencies. The latter we are wont to call the voluntary non-profit community agencies. There are some fairly well established traditional lines of differentiation; most operations involving the non-commercial dispensation of money are in government hands—or at least have been in the last two decades—whereas personal counseling services are almost entirely operated by non-

governmental agencies. These lines of demarcation are neither fixed nor identical from community to community or from state to state, and I wish to emphasize the similarities and identical features of the two types of agencies. While both stem from motivations harbored by citizens, there is a tendency to see governmental agencies as more removed, less controllable and hence more authoritarian than non-governmental community enterprises. On the whole this view is probably realistic if only because government, as a much larger organization, requires a much larger apparatus of rules, safeguards and administrative devices, which in general are apt to lead to arbitrary and rigid decisions as experienced by individuals in their dealings with government offices.

However, since government is still people we also have to recognize that human propensities towards power and towards dealing with others as quasi-dependents exist and that certain organizations and administrative structures facilitate these individual traits. There is little question that non-governmental agencies have succeeded generally in avoiding authoritarian tendencies when dealing with their clients. It is much more doubtful that they have been equally successful in curbing procedures by fiat in dealing with each other and with general community problems. This failure of voluntary agencies to achieve harmonious integration with each other and with government agencies in a total community effort commensurate with community needs is rooted in sectarian motivation.

By "sectarian motivation" I am not referring to sectarian agencies in the usual sense—denominational agencies—but the fact that by tradition, through excellence of a particular service, through association of an agency with socially gratifying activities or a reputation to the same effect, through dominance of a section of the population, certain agencies or groups of agencies become sectarian in the sense that they employ and utilize—sometimes preempt—community motivation to serve only a segment of community needs. There are two types of this sectarianism. For instance, here is a city with a dozen hospitals, but one hospital has been so successful through various devices that its auxiliary includes such a high percentage of all volunteer personnel available for community work that other hospitals cannot even form an auxiliary and other community efforts get but slight attention. Similar examples could be cited from other communities not involving hospitals necessarily.

The other type of sectarianism and sectarian motivation follows categories of problems and usually is of national rather than community-wide proportion. Particularly in the health field, thoughtful observers have watched with alarm the trend towards campaigns against specific diseases. The psychiatrist can only deplore the collection of vast amounts for service and research on diseases whose prevalence is almost microscopic compared to that of mental illness. The public health student can but feel disturbed by the inequities of resources—human and material—to combat different health problems, inequities brought about to a considerable extent by one-sided mobilization and utilization of individual motivation to volunteer service or support. The medical educator can only deplore a trend towards more specialization sparked in part by the same factors—availability of funds and facilities—a trend which can become a threat to well-considered educational programs and to comprehensive medical care for the individual patient. Lastly, the community leader and worker can but regret the diverting of

motivation to serve and give to national compaigns when his community lacks facilities in areas where no national organization helps out, but which may be locally more vital and urgent than meeting national fund quotas for problems that may be of subordinate urgency in the community.

I do not wish to advocate provincialism, but as the establishment of United Fund campaigns illustrates every community has to come to grips with this problem—and more often than not the community is on the defensive here. One reason for this is related to the type of appeal or, to remain within our frame of reference, to what motivational facets are being stimulated.

For instance, there is nothing easier than to arouse motivational forces related to insecurity and threats. Unless such exploitations run into a situation where high individual or group defenses already exist it is easy to utilize fear-motivated energy for action. Let a newspaper carry a story of a heinous crime in a residential neighborhood and you will find increased activity in that neighborhood's organization; all will concentrate on the problem and evolve better or less well conceived remedial programs, whether they involve government participation or not. In brief, utilization of motivational forces related to fear and insecurity is to be discouraged and in the long run is more apt to distort and mischannel community efforts and to disregard proper proportion and interrelationship of community needs.

It is desirable and I believe axiomatic that those motivational forces should be utilized which arise from the need to participate with individuals outside the family group and which strive for satisfying goal-directed interaction. Furthermore, this utilization should maintain and emphasize community identity and a community-wide outlook in addition to sectarian or agency identification. It must be recognized that it is easier to instill morale and unify a group in opposition to other groups and enterprises than to integrate a particular cause harmoniously with other possibly divergent goals. Identification with an agency is essential to the wholesome group process but it must not become so sectarian as to preempt volunteers' emotional motivation to the exclusion of other and broader visions. Almost thirty years ago a wise board member wrote ten commandments for board members that are just as pertinent today, with very few modifications, as they were in the 1920's. His first commandment read: "To know why your organization exists and to review annually why it should exist," or as I would paraphrase it, to reconsider the agency goals, its adequacy in meeting them, its role in the community and therefore the appropriateness of its goals in the light of general community needs.

In the typical community we find a clustering of volunteers on two levels surrounding a layer of non-volunteers. We find volunteers engaged as unskilled assistants to trained workers doing a job—auxiliaries in hospitals, Gray Ladies, Red Cross drivers or blood collectors. And we find volunteers on the boards of the same agencies or as the driving forces in Community Chests and United Funds. Often a volunteer hierarchy exists or develops where one can move from arranging flowers in a hospital room to become director of volunteers (if he isn't a professional), on to the board of the hospital and further on to head the Chest or Fund drive (after ascending the ladder of its officers corps), reaching thus the pinnacle of volunteer careers within the community. Of course, if you take your Fund over the top, volunteers from other communities will come to find out how you did it and you may find your-

self propelled onto the regional and national scene.

The same "volunteer careers" are open via the Parent-Teachers Association or the League of Women Voters, service clubs and others. This is, of course, wholly desirable. First within community limits and then beyond it a volunteer enlarges his vision and viewpoint from a small focal spot toward ever-widening vistas and an ever-broadening spectrum of problems.

Unfortunately, it doesn't always happen that way, or not quite that way. Rare is the larger community that has not had or is not having a battle between its Council and its Chest or Fund—if you forgive me for using old-fashioned terms for a moment —the "professionals" in the Council against the "volunteers" responsible for the fund drive. Often these controversies reflect in part divergent sectarian interests within a community as well as conflicting local and national concerns.

Let us return now to a further consideration of parallels between government and so-called voluntary agencies. Although there exists a hierarchical structure within which volunteers can rise, individual volunteers are often insufficiently acquainted with the activities and goals of their agency staffs. In well-functioning agencies staffs and boards are thoroughly integrated, but I believe often at the expense of community integration. I do not have to spell out for you how arbitrarily budgets are fixed when the Fund pie gets sliced and how the Fund goal is often kept within the limits of the attainable to avoid undue risks of failure on the one hand or upsetting the community by letting them know that not all is well on the other. Instead of behaving as ambassadors and interpreters of agency and community needs, let alone as community leaders, the volunteers tend to "administratise" the community health and welfare program in the same bureaucratic manner that we attribute only to the government. Rare indeed is the Fund or Chest drive that includes education about and emphasis on what the community does not have but ought to have or what it doesn't do but ought to do—and that it will cost a lot more money.

For instance, in the last few years an entirely new community problem has arisen with the introduction of new drugs in the care of the mentally ill. Just as ten years ago in the tuberculosis field, now in the mental health field increasingly large numbers of partially recovered patients are returning to their communities. As is well known, only a concerted well-integrated community program involving all health and welfare services can meet the needs of these patients. How many communities are so prepared or are so preparing themselves? How many Chests or United Funds have declared: "We have to raise our goal 10% to 15%—whatever it takes to meet this emergency constructively—in addition to our usual annual increment?"

Where should such a campaign begin? With the psychiatrist, the state hosiptal, the community volunteer or the social worker in the family service agency? Unfortunately, there is little precedent for sufficiently meaningful communication between agency staffs and the volunteers affiliated with them to permit effective and realistic consideration of such a complex problem. And this points to the heart and the central issue in the utilization of volunteer motivation. Orientation in the program of one agency and its mode of operation is insufficient education in two respects. It may not include sufficient emphasis on community-wide problems but, more important, it rarely helps the volunteer to understand his role.

If the volunteer—including the "professional"—is to become really acquainted with his role he must understand something of his motivational forces. We ignore well established psychodynamic tenets when we act as if education were a purely intellectual matter. At least the volunteer must be helped to recognize or accept consciously or unconsciously that his volunteering is related to a need for meaningful group activity and communal participation. Mr. Davis's second commandment reads: "To govern a board or a committee through joint thinking and not by a majority vote." I can only add that you cannot share thinking without sharing feelings.

Although we are just beginning to understand group processes, some principles can be stated. Whether the group is a family, a sales organization, an army platoon, a health agency, a school class or a high policy-making body, its morale determines its effectiveness. Leadership in turn determines its morale, and a good leader helps to identify the goals of the group and to strengthen its faith in its social purpose. He also promotes mutually beneficial relationships within the group by facilitating partial identification with himself, and finally he exemplifies integration of the group into the larger organization to which it belongs.

Dr. Coleman indicated that we believe only group discussion, under appropriate leadership, of the social role of the volunteer can lead to the fullest utilization of volunteer motivation, *i.e.*, we seek to stimulate education about volunteer work which transcends intellectual exchange of information about one agency or one community. We seek to stimulate the identification of the constructive and personality-maturing forces that operate so successfully within the family, because they are essential to other successful group enterprises. We seek to stimulate an understanding of how to put them to use in community work for all volunteers.

As to the nature of the motivation of individuals or of groups, Mr. Davis indicated this too in his tenth commandment: "You must combine," he said, "a New England conscience with an Irish sense of humor."

REFERENCES

American Public Health Association, "Official Statement on the Local Health Department," *American Journal of Public Health,* 41(1951), 3.

Barhash, A. Z., Mary C. Bentley, Milton E. Kirkpatrick and Helen A. Sanders, *The Organization and Function of the Community Psychiatric Clinic,* New York, National Association for Mental Health, 1952.

Belin, C. R., "The Citizen's Contribution to Nursing," *Nursing Outlook,* 4(1956), 25.

Brown, M. B., "What Makes a Successful Director of Volunteers?" *Hospital Management,* 80(1955), 60.

Cartwright, Dorwin and Alvin Zander, *Group Dynamics: Research and Theory,* Evanston, Ill., Row, Peterson & Co., 1953.

Coleman, Jules V., "Motivation of the Volunteer in the Health and Welfare Fields," *Mental Hygiene,* 41(1957), 217.

Davis, R., "Ten Commandments for Board Members," *American Journal of Nursing,* 29(1929), 644.

Lemkau, Paul V., *Mental Hygiene in Public Health,* New York, McGraw-Hill Book Co., 1955.

Lindeman, E., informal discussions of the Wellesley Community Project.

Mackey, B. B., and others, "The Sutter Hospitals Have 500 Ambassadors," *Modern Hospital,* 84(1955), 98.

Malamud, Irene T., "Volunteers in Community Mental Health Work," *Mental Hygiene,* 39(1955), 300.

Stevenson, George S., "Dynamic Considerations in Community Functions," *Mental Hygiene,* 34(1950), 531.

Waelder, R., "The Problem of Freedom in Psychoanalysis and the Problem of Reality-Testing," *International Journal of Psychoanalysis,* 17(1936), 89.

DONALD BLAIR, M.A., M.D., CH.B.,D.P.M.

MAIR BROOKING, A.R.C.M.

Music as a therapeutic agent

This article is suitably dedicated to the memory of Dr. S. D. Mitchell, who was a great protagonist of music therapy in mental illnesses. It describes various ways in which we have applied music at St. Bernard's Hospital (a 2,400-bed mental hospital), the investigations we have conducted into certain aspects of its uses and the results we have obtained.

HISTORY

The application of music to treat mental patients is not a novel conception. Indeed ever since primitive man first endeavored to cope with mental disorders music has been used therapeutically in devious ways, with fluctuating enthusiasms and varying degrees of success. It is not relevant for us to describe here the history of music therapy. Suffice it to say that there are many classic examples of its application. The nineteenth century saw the advent of numerous mental hospitals and from their inception the value of music for entertainment and religious purposes was appreciated and utilized. During this century the British Council for Music in Hospitals has been helpful in providing classical concerts by expert musicians. Apart from this there has been in some quarters a strong endeavor to encourage patients to produce their own musical entertainment through the medium of a patients' orchestra or percussion band. Although there are records of many important persons with deranged minds being treated individually by the production of music (for example, Saul's epileptic outbursts being soothed and placated by David's harp; King George II of England and King Philip V of Spain being roused from their melancholia by music), as yet very little has been done to use music for the treatment of individual patients in the

Dr. Blair is consultant psychiatrist and Mrs. Brooking music therapist at St. Bernard's Hospital in Southall, Middlesex, England.

modern field of psychiatry. It seems that music has so far been applied too vaguely and with so little knowledge of its real potentialities that definite indications for its optimum utilization in any patient have as yet been lacking.

PLAN OF ACTION

In February 1955 Mrs. Brooking started at this hospital as a music therapist for two half-day sessions a week, increased in due course to four such sessions. The cooperation between a skilled psychiatrist and a skilled musician within the precincts of the hospital seemed to afford the chance for new investigations and we have since then worked together as a team endeavoring to explore novel vistas of music therapy.

In defining our plan of action we were influenced by the following considerations:

1. The comparatively short time during which the music therapist would be available.

2. The various ways in which music may be expected to influence patients beneficially.

3. The various types of patients being dealt with and the modes of therapy already being used.

4. The place that music must reasonably be expected to occupy in relation to these other treatments.

We decided that the 16 hours a week should be divided into half-hourly and hourly periods for the purposes described below.

SOME EFFECTS OF MUSIC

There can be no doubt that music has from man's earliest days exerted extremely potent influences upon him both individually and communally. The potency of rhythmic music on primitive societies is evident to all who have witnessed it, as one of us has done. It is used in all forms of activity (for example, war dances, wedding dances, working songs and religious rituals), and a great deal of the satisfaction that it induces seems to stem from the chantings and bodily movements which almost invariably accompany it. As man became more civilized melody and harmony became more pronounced in music and these have usually induced pleasurable mental and bodily relaxation. Finally the advance to the higher levels of classical instrumental and orchestral scores has allowed the listener to indulge in new realms of thought and fantasy prompted solely by music. There is not the slightest question that modern civilized men differ enormously in their response to the various categories of music, to the different compositions within one category and from time to time to any specific composition according to their mood and circumstances. A particular piece of music may have a particular significance for any individual by virtue of its associated memories of past events.

Every person must be considered a complex entity in his responses and reactions to music but, broadly speaking, music may be said to exert the following influence in varying degrees on almost anyone:

1. Music of all categories may produce pleasure for the listener by merely being heard.

2. Rhythmic music is the basis for the deep satisfaction experienced from the various types of dancing.

3. Certain compositions can stimulate a person's affect and emotions and produce feelings of exhilaration and excitement.

4. Some pieces have a soothing and relaxing effect upon mind and body.

5. Certain music can rouse the imagination and give rise to new thoughts.

6. Some tunes may revive past memories, either pleasurable or painful.

7. Some people enjoy the study of music as a subject and increase their knowledge of the works of famous composers and of the theory of music.

8. Participation in the production of music in one form or another affords the majority of human beings a feeling of great satisfaction. A few obtain satisfaction from individual performances but group activities are favored by the majority. In either case an elevating feeling of accomplishment is aroused in those taking part in these activities and an attendant feeling of social fellowship is experienced.

Music may produce beneficial effects in all the above ways.

TYPES OF PATIENTS AND TREATMENT

St. Bernard's Hospital is virtually divided into two sections. In the larger section are chronic patients cared for and treated as far as possible. Here are all the types of illness usual to such wards. The smaller section is devoted to the treatment of recent admissions. The majority of recent admissions (apart from patients suffering from senile dementia or organic diseases of the nervous system) may be diagnostically grouped under three headings: depressive states, schizophrenic and schizophreniform patients, and all types of psychoneuroses.

The most serious problem confronting the hospital is that of obtaining the maximum efficacy of multidimensional treatment for the recent cases. Any measure calculated to abbreviate and fortify treatments already in use would be most welcome and we believe that it is here that music therapy may have a part to play. The tremendous advances made in psychiatry during recent years have been responsible for the modern psychiatric therapeutic armatorium. All modern methods of treatment are in use at St. Bernard's Hospital and the question whether music therapy as such is to be included among them remains to be seen.

At the time we commenced our work music was being used in this hospital for the usual entertainment and dancing purposes. There is room for considerable improvement in these musical activities under the guidance of a music therapist, but in view of her limited time available we decided that it would be advantageous to ascertain the value of certain other uses of music among recent patients. For administrative convenience it was necessary to limit these activities to a ward for recent admissions containing 60 patients, all female.

METHODS

After much consideration a weekly program was devised and has been adhered to for the last nine months, during which the music therapist has been available for four half-day sessions a week.

Group singing has attracted an average attendance of 30 patients. From the psychiatric point of view this is intended to afford them pleasurable occupation and the benefits mentioned in paragraph 8 above. This group is attended by any patient who wishes to do so.

The percussion band was devised with an objective similar to group singing but also with the intention of using it to produce music that would allow some sublimation of repressed aggression without requiring participants to have any previous skill with musical instruments. The average size of this band has been 15 patients.

The musical appreciation group was ar-

ranged for patients who enjoy the study of music as a subject. Any patient requesting to join the group is always allowed to do so. This group averages 12 patients.

Each small group contains six patients with a similar diagnostic illness. Thus Group 1 contains only depressive patients, Group 2 schizophrenic and schizophreniform cases and Group 3 psychoneurotics. The general intent is to give them an opportunity to hear compositions in the main categories of music but varying widely in quality and to try and observe any differences in the reactions among the three groups and among the patients in each group.

Individual therapy has been utilized in two different ways: (1) Pianoforte lessons are given to individual patients with reasonable efficiency in music who had learned to play the piano in the past but who have not played during their illness and sometimes not for many years previous to it. (2) Music is used for the purpose of producing certain definite effects on individual patients. This latter method calls for the closest cooperation of all between the psychiatrist and the music therapist. From his knowledge of the patient the psychiatrist decides the effect he wishes to be achieved. He then discusses the patient with the music therapist, explaining the prevailing situation and the purpose for which he wishes music to be used and leaves it to her to try and accomplish this purpose. The various objectives aimed at are:

1. Reducing anxiety, agitation, irritability and emotional tension and producing mental and bodily relaxation.

2. Relieving severe depression.

3. Stimulating emotional reactions and interests in dull and apathetic patients.

4. Reviving significant past memories.

5. Mollifying resistance to psychotherapy.

Consultation between the psychiatrist and the music therapist is deemed to be of the greatest importance. Unfortunately this cannot be held as often as desirable but a regular meeting takes place every Friday afternoon.

Group singing and percussion band ac-

Weekly Program

TUESDAYS		FRIDAYS	
10:30 a.m.–11:15 a.m.	Individual patient	10:30 a.m.–11:15 a.m.	Individual patient
11:15 a.m.–12:00 m.	" "	11:15 a.m.–12:00 m.	" "
12:00 m.–12:45 p.m.	" "	12:00 m.–12:30 p.m.	Small group 1
2:00 p.m.–2:30 p.m.	" "	2:00 p.m.–2:30 p.m.	Small group 2
2:30 p.m.–3:00 p.m.	" "	3:00 p.m.–3:30 p.m.	Individual patient
3:30 p.m.–4:00 p.m.	Small group 3	3:30 p.m.–4:00 p.m.	" "
4:30 p.m.–5:00 p.m.	Individual patient	4:00 p.m.–5:00 p.m.	Conference (music therapist and psychiatrist)
5:00 p.m.–6:00 p.m.	Group singing and percussion band	5:00 p.m.–6:00 p.m.	Music appreciation class

tivities go on in a large, pleasant common room admirably suited for them. We were fortunate in obtaining another smaller room approximately 14′ x 17′ for the other activities. This room has a grand piano and an electric gramophone. A couch is there for the patient who wishes to recline and there are comfortable armchairs to accommodate members of the music appreciation group and the special groups of 6. The room is located about 20 or 30 yards from the nearest ward, allowing patients a feeling of security from the observation, interruption and listening of other patients. We have found this of great import.

TECHNIQUES

The techniques described here are based on the results of the comparatively limited experience we have had.

The personal relationship between the music therapist and the patients, either in the groups or in individual therapy, has been found to be of paramount importance, as the psychiatrist had anticipated. The mere playing of instruments or gramophone records in a routine fashion is comparatively ineffective. The function of the music therapist is, so to speak, that of a catalyst greatly enhancing the various effects of the music on the patients.

Certain general principles are applicable to all forms of music therapy. First is the importance of the music therapists's obtaining a reasonable degree of rapport with her patients. Second is the necessity of arousing the patients' interest and attention by selecting appropriate music. Third is the necessity of commencing any session by matching the music played to the prevailing mood for the patient or patients concerned and from there working towards a specific objective.

Group singing has attracted a heterogeneous group averaging 30 patients. The personnel of this group has changed because some patients have left the hospital, others have been transferred to other wards and new patients have taken their places. They present the usual varying degrees of positive and negative interpersonal emotional relationships but it has been found that if one can develop interest in the leaders other members, including even stragglers, will follow suit. The first step is to find a song which arouses enthusiastic response from a few; this is usually a folksong or one of those commonly taught in schools, such as Handel's "Where'er You Walk." Once they begin singing the rest will usually follow. General interest is kept alive by encouraging individuals to express their personal choices of songs to be sung and fostering a group spirit of mutual support. Members will cooperate in other songs while waiting for their own request to be sung. A successful policy is to intersperse one or two new songs each week amongst old favorites.

The same principles as for the group singing are used with the percussion band. After the instruments are handed around any music with a pronounced rhythm is played on the piano while patients explore the use of their instruments. (A person's interest in this form of musical activity may easily be aroused even if she has little experience and few ideas in music.) This is followed by dividing the group into sections (each section taking part of a bar) and where possible achieving cross rhythms, *e.g.*, ⅔ and ¾. Music with a strongly accentuated beat, fast enough to release much energy and slow enough not to strain the span of attention, is found to be the most effective.

One hour a week is reserved for the music appreciation group. Patients are invited to come and listen to music and to ask ques-

tions and enter into discussion about it. Programs are arranged to suit as many members of the group as possible.

In the groups of 6 the music therapist plays suitable compositions on the piano and uses the electric gramophone for appropriate orchestral records. The first objectives are to afford pleasure, stimulate the emotions and produce beneficial reactions. These reactions are encouraged by group discussion and criticisms and by allowing the patients the choice of pieces to be played and fostering in the music room a congenial happy atmosphere. Thereafter the therapist endeavors to assess the reactions of the groups to different types of music. She chooses certain pieces for this purpose and disperses them among choices from the group.

In working with the individual patient it is a fairly simple matter to relieve tension in even the most "highly strung" by playing the piano. Gramophone records are not anything like so successful. But picture music written for orchestral instruments is a powerful means of stimulating the imagination.

Reviving the patient's associations with the past is necessarily tied closely to particular music which can be discovered only by talking to the patient. Subsequently this can be used at will to bring up this same memory, which in its turn can spark off a train of others. So far the most successful method in following this up has been to use gramophone records as a background while encouraging the patient to talk.

A change of mood is most easily induced by the therapist playing the piano, personal contact (musical) with the patient being the vital experience here. It has proved possible to control mood almost bar by bar with neurotic patients. This is also the most effective means of bringing unconscious memories to the surface, since in this contact split-second changes of mood and tension often produce the desired effect.

RESULTS

Our year's work may perhaps best be described as exploration and reconnaissance. We have no startling results to reveal and we make no firmly established claims. We believe the experience we have gained and the results we have witnessed provide indications for further investigations which may result in a more valid assessment of the potentialities of music therapy, and this applies particularly to its use with individual patients as opposed to groups.

The results obtained from group singing have been those that we had anticipated and that had been obtained by other people using this method. Nevertheless a few special features are worth recording.

The majority of the patients in the ward concerned, no matter what their diagnosis might be, have tended to have feelings of inadequacy and inferiority, to be self-preoccupied with their particular worries and troubles and to find difficulty in social contacts and group activities. Therefore, sessions usually commence with patients in rather a dispirited state and an atmosphere of indifference or even resentment. Often patients have had to be strongly encouraged and exhorted to attend the meetings. It has been noticeable that on every occasion enthusiasm rose as events proceeded until at the end of the session good cheer and smiles prevailed.

As a result of observing patients' remarks and behavior there is no doubt in our minds that they nearly all obtain considerable satisfaction from the process of singing together. During the year four small concerts were given by this group to the chronic patients in other parts of the hospital. The

initial reception of the idea of a concert was smiles and enthusiasm, often followed by such anxiety, trepidation and doubt that in the final days before the concert special persuasion had to be exerted on some patients to make them attend the sessions. Although the quality of the concerts varied the final program was always fulfilled and the reception from the audience always favorable. After the concerts the participants invariably revealed considerable satisfaction in their accomplishment and concomitant improvement in their self-respect.

It has by no means been easy to interest this group in participating to their maximum benefit. The results obtained have depended largely upon the personal relationships between the music therapist and the group. The advantage of a skilled musician who can instruct and encourage patients and vary the program according to needs is of great import.

Although the remarks just made regarding the group singing apply equally well to the percussion band, it has been evident that individual patients obtain great satisfaction in the type of instrumental activity they perform. This applies to patients who have such poor singing voices they cannot take part in the group singing.

The music appreciation group has been attended by the more musical members of the ward who obtain satisfaction from learning more about music and from hearing works of famous composers. The participation in criticisms and discussions has been beneficial. Most of them were reluctant to say much at first but as time went on were able to express themselves with increasing fluency to their delight. Several of them have remarked how glad they would be to be able to participate in musical discussions after they have left hospital. The weekly session seems to be of real therapeutic value. It can be conducted only by a skilled musician.

We have failed to find outstanding differences in the reactions of the three small groups of 6 patients. This may be largely because patients of all three types have had treatment oppropriate to their conditions and by the time they attend these musical activities have nearly always recovered from the acute phases of their illness. Thus the depressive patients have had ECT and while still depressed are not acutely so; the schizophrenics have received chlorpromazine hydrochloride (Largactil) treatment and by the time they attend the classes are not in a state of acute schizophrenia; the psychoneurotics are receiving psychotherapy and their condition when attending varies of course according to the fluctuating emotional phases of their treatment.

There is no actual yardstick for measuring results in these groups, but as a result of our observations over nine months we have found broadly speaking that each group responds to the various categories of music in similar ways but with varying tones of emotional reaction and with certain individual variations in each group. All groups seem to find the same types of music and composition either pleasant or unpleasant. Each group finds pleasure in soothing and relaxing types of music; each also enjoys popular melodies and music of a stimulating character and dislikes sad or loud music.

The schizophrenics react in a minor tone. At first they were very lukewarm and took longer to respond. As they have attended more sessions their interest and attention have improved and their emotional reactions have increased. They gain pleasure in the meetings and frequently tell the Ward Sister they are looking forward to the next session.

Depressive patients are very susceptible to music they like and are particularly antagonistic to excessive volume and pronounced rhythm. The appropriate music undoubtedly relieves their depression and some of them say they look forward to the sessions as the only times when they really feel relief from their symptoms.

As might be anticipated, the outstanding characteristic of the psychoneurotic is emotional instability. They therefore react to their likes and dislikes with intensity and as a whole express their enthusiasms more loudly than the other groups.

From time to time individuals differ from the general pattern of reaction; for an indiscernible reason one patient may detest a composition that the others find pleasant. This probably results partly from variation in individual taste and partly from emotional associations that are aroused. One depressive patient was moved to tears as soon as music was played and would not attend the group after the first few sessions.

There is one other feature amongst the youngest patients of all groups, namely, the fact that when they are at the worst phase of their illness they dislike rhythmic music but as they improve it appeals to them more until in some of them it becomes the most enjoyable form.

INDIVIDUAL THERAPY

It is very difficult to convey in print the effect that music has had on individual patients. The only way to really appreciate this is to be in personal contact with the patient throughout the music session as the music therapist is or to see them before or after the session as the psychiatrist does. Perhaps the best way to portray results would be to publish all psychiatric histories and the reports of each session made by the music therapist, but this is of course impracticable, would make very tedious reading and would not in the absence of personal contact with the patient really reveal the situation.

All patients receiving individual music therapy have also received other routine treatments and on no occasion are these curtailed or replaced by music therapy. We should make it clear that patients have not attended for merely one session but for a varying number (2 to 42) according to their reactions and needs. Moreover, although we have specified individual objectives for this treatment, frequently we have attained more than one objective with the same patients in the course of therapy.

Music tuition has been given to two patients who had previous musical experience and to one so artistic and talented as to warrant our encouraging her desire to learn to play the piano. Anyone witnessing the progress of the first patient (a schizophrenic) could have little doubt regarding the benefits she obtained from regaining her ability to play the piano. The second patient with previous musical experience was a highly skilled musician who, largely because of her neurotic condition, had unbalanced ideas about her music potentialities. The music therapist was able to obtain her cooperation and make her realize the limits of her music prowess, so that she now has a good perspective in this matter and having left the hospital is happily participating in appropriate lessons and achieving the maximum success of which she is capable. This result could not have been obtained except by a skilled musician-therapist able rapidly to effect good *rapport* with the patient. The third patient, who is highly artistic and competent, is making rapid strides in learning to play the piano, which she says gives her the

greatest feeling of accomplishment in her life.

All the patients receiving individual therapy for other purposes have been psychoneurotics and the total number treated during the year has been small. Results must therefore be considered as tentative.

Music has been effective in soothing anxiety and emotional tension in every patient referred for this purpose. Patients spontaneously acknowledge the relief they obtain and this is obvious to witness. The effect, however, fades out after a session is over and it is usually only in the course of a number of sessions that a more permanent effect seems to be achieved. One must remember that these patients, as we have already pointed out, are having other treatments and one cannot state specifically that their improvement was the result of music therapy, but from our own experience we have little doubt that in each case this is at least a valuable aid to other forms of therapy.

We have found that during a music therapy session relief of depression can nearly always be achieved even with patients not responsive to other forms of treatment. Again the effects fade after each session but patients express gratitude for the momentary relief they obtain which seems to us to be of real importance in their over-all progress.

Two apathetic patients were referred. One who had been in a state of emotional apathy and lack of feeling for a fortnight, resistive to psychotherapy and other treatments, regained her emotional feelings as a result of music therapy. This was achieved partly by the production of fear reactions (which occur very easily on hearing certain music compositions) and in contrast the production of pleasurable reactions. The second patient who was apathetic in her reactions was aroused to a greater depth of response in the course of several sessions.

It was found that music was a potent means of reviving past memories and that these were frequently expressed during the course of therapy undertaken for some other purpose. One patient who had been in a state of agitation and tension for a considerable time received special benefit from a revival of pleasurable past memories with music. She has improved sufficiently to be about to leave the hospital and is emphatic in her opinion that music therapy initiated her improvement and has been largely instrumental in her continued progress. Another agitated patient who attended a small group for psychoneurotics disliked all kinds of music until one day a piece was played that had special associations for her. That day it was decided to give her individual therapy and this proved of great value in combating the severe agitation and depression that she experienced.

Two chronic cases of neurosis with a resistance to psychotherapy that had not been amenable to any other methods were referred for music therapy. The first case had 20 sessions of treatment. At first the resistance seemed to be mollifying and she became more frank and communicative. However, thereafter she seemed to become unconsciously fearful that her resistance might be broken, gradually retired into her shell again and refused to continue treatment. The second case is still in the course of treatment and so far has become more free in discussing her case and more cooperative psychotherapeutically.

From personal observation, although it is still limited, of the progress of the patients that have been dealt with we have little doubt that music influenced individual patients in all the ways we have described and we are of the opinion that it can be a valuable aid to psychotherapy.

Finally we must emphasize that patients

may attend any of the various types of therapy we have mentioned, except that as a general principle those receiving individual therapy do not attend the small groups. Nearly all patients having the latter two therapies have voluntarily attended group singing and a number of them also attended the music appreciation class. Thus the total benefits obtained from music therapy by any one patient have been dependent upon the various branches in which she participated, but we have already indicated that each activity is devised to benefit the patient in a different way. Patients having individual therapy have not wished to attend other forms of music activity during their worst phases.

It is probable that all the cases we have dealt with would in due course have responded to the other forms of treatment available, but we think music has been outstandingly beneficial in relieving their acute phases (agitation, depression, etc.), in affording them, almost without exception, pleasure to a degree in depth they receive from no other activities and in stimulating their interests and enthusiasm in a manner not achieved to a similar extent by other activities.

We believe patients can be influenced in individual sessions in a beneficial manner that is not possible when they attend in groups. This is particularly important in certain mental states including the acute phases of a psychoneurotic illness. The effects to be attained by individual therapy depend greatly on the personal relationship between the music therapist and the patient and the ability of the former to maintain good *rapport* with the latter and on the therapist's knowledge and skill in dealing with that relationship.

We do not have to emphasize the potency of music on the emotional reactions of any ordinary person and this is of course more evident in many patients suffering from mental illness. It is therefore our belief that it is highly undesirable for a psychotherapist, even one who is a skilled musician, to participate in music therapy activities with his patients. Many patients have such a craving to have pleasurable music played to them that it would be inadvisable for it to be supplied by their psychotherapist because of ensuing emotional involvements.

CONCLUSION

We have described the results of our year's work in music therapy. Any conclusions to be derived from them can of course only be tentative and much further work is required in this field. In view of the vast progress in modern psychiatry the question arises whether there is any room or need for music therapy along the lines we have detailed. Assuming the psychobiological outlook on any patient and the multidimensional therapeutic approach, we believe music therapy has a part to play which may be found to be at least as important as the part played by art therapy.

It is our contention, however, that the mental attributes associated with the appreciation of music are so complex, the variations of response so vast from one individual to another and from one time to another within the same individual, the variety of musical compositions so enormous and the circumstances of each person so changeable from day to day that no scientific statistics are ever likely to be produced for music therapy. It is only personal contact with the patients that can enable one to appreciate the potency of music as a therapeutic agent and only clinical observations that are likely to vindicate the use of music therapy and the desirability of employing a music therapist in a mental hospital.

WILLIAM G. HOLLISTER, M.D., M.P.H.

The risks of freedom-giving group leadership

One of the hallmarks of the American scene is the freedom with which we criticize our leaders. From the neighborhood barber shop to the nearest backyard fence we examine and cross-examine those who assume or accept leadership. Keen observers of the realm of politics have often studied this phenomenon. Veteran convention-goers are well aware of the chorus of critical "If-I-were-running-this-show" comments that rise in the hallways and back rooms after the first day's enthusiasm has died away.

Mental health education leaders experimenting with new methods also have become aware of the "hostilities" toward the leader that can develop. Some have become so concerned about these phenomena that they have voiced serious questions about the value of certain group methods.

Now that Bion (1), Thelen (2) and others have begun to identify states through which some small groups tend to pass it has become possible to identify and describe in more detail the forces behind these criticisms of the leader. The observation that these reactions against the leader appear to fall within a general pattern makes it possible to more or less predict some of these reactions as the calculated risks of group leadership.

Do these risks always occur? In what kinds of groups do they arise? Can they be avoided?

Oddly enough, it is possible to lead and never become aware of any counter-reaction to one's leadership. First, people usually "take apart" a leader when he is not around so that often he never hears the diatribes against himself. Second, the majority of

Dr. Hollister is consultant on mental health in education for the community services branch of the National Institute of Mental Health.

groups in our culture are run in a controlled way that keeps "leader hostility" bottled up or carefully re-directed.

The fullest measure of resistance to the leader appears to develop in groups that meet for a week or more and allow their members a free voice in expressing their feelings. Such resistance is best seen when the group is helped to or allowed to progress through the four stages of group development as identified by Thelen. Bion classified them as the steps of dependency, counter-dependency, independency, codependency and interdependency. Progress through these stages or steps involves freeing a group from its dependency on the leader and the maturation of the group to higher levels of cohesion, cooperative action and group thinking where individual differences are accepted and used and where individual growth is enhanced. In these processes lie the calculated risks of group leadership.

It is possible, however, to avoid resistance to the leader by keeping a group "dependent" or by ingeniously devising ways to drain off the "leader hostility." For instance, a crowded program of lectures with no time for discussion postpones any expressions of resistance until the group is out in the halls and cloakrooms. Another pattern of control is that of organizing the program so that when critical forces begin to appear they are re-directed by assigning members to buzz groups, work groups or committees which must carry out certain tasks under time pressures. Thus increasing the pace, creating too big an agenda to complete and keeping the length of the conference short all limit the opportunity for expressing criticism—at least on the floor of the meeting.

To summarize: Short-term, leader-dependent, production-centered groups permit less leader resistance to develop; long-term, high participation, individual-centered, free expression groups permit fuller development of this phenomenon.

For further clarification it might prove rewarding to consider in detail the following questions: What is the pattern of leader resistance? What are the risks the leader encounters in allowing a group to mature? By using Bion's stages of group development as a reference and a fictitious discussion-leader training group that is mental health oriented as a model, we can trace some of the typical risks a leader of this group might face. Before considering the group itself, however, it is important to note those phenomena that precede its formation.

PRE-TRAINING COURSE RESISTANCES

From the literature of group dynamics and confirmed by our own experience we have seen how the most carefully worded announcements of a course and statements of its purpose become twisted by prospective participants. Each one—reading from the viewpoint of his own needs, dynamics, background and semantics—interprets the course's purpose in his own way and builds up expectations of the leader such as were never dreamed of by the leader. Before the leader meets the group the first strike has already been called, for no person (or team) can possibly meet the range of the participants' expectations. Inevitably the expectations of some group members will be frustrated and some of them will blame the leader for this failure to meet their needs.

In addition, all prospective participants have had experience with leaders before—their fathers, bosses, teachers and others. They therefore carry around emotional images of leaders, some favorable, some not. The potential participants of a training group thus form pre-images of the leader—

"he is an expert . . . he has the answers" or "he'll push us around . . . he doesn't know as much as I do." Even before the group assembles some already like, and others anticipate disliking, the leader. In addition, after they meet the leader many will react to him not in terms of what he is really like but in terms of the pre-image they project upon him. When they find he doesn't fit this image, frustration and realignment of their conception of him are inevitable and these in turn color their relationship to him. Thus the leader has two strikes against him as our fictitious training group assembles.

EARLY REACTIONS TO THE LEADER

Assuming our hypothetical discussion-leader training course is mainly designed not to give information nor solve a problem but to strengthen the participants in leading discussions, to help them acquire security, poise, flexibility and sensitivity in working with groups, then it is important that the trainees be allowed to experience some of the normal phenomena that occur in groups. Experience has too often shown that a course based on the giving of information by experts leaves trainees dependent, insecure and unskilled. On the other hand, allowing participants to discuss information, pose problems, solve them, play various roles and practice leading the group in their own way creates a better opportunity for them to develop by discovering their own skills, thinking through their own situations, achieving their own sense of security. In our experience this type of training gives participants a greater capacity for performing independently and a greater ability to work interdependently with others. If this approach is what we want, we must be prepared for the reactions to the leader that will arise.

THE DEPENDENCY EXPECTATION

Borrowing from Bion's perceptions, we can expect that many of our trainees in this course will come to the meeting expecting to be dependent. They will expect the leader to feed them a pre-digested intellectual pablum that they can painlessly take in. They will be delighted with lectures, charts and pamphlets but will soon be disappointed when the leader—knowing that learning involves more direct participation —begins to present problems for solution by discussion. Soon one hears, "Why doesn't he answer these questions? . . . We need a lecture. . . . Too many members are talking. . . . Let's have our leader tell us." As their dependency expectations are frustrated they become confused, anxious or even angry, and blame the leader or other members of the group who are now beginning to emerge as leaders. In defense, the dependent ones may build themselves into a sub-group and demand that the leader "take the course back . . . we need a planned, structured agenda." The leader who believes in group members' taking responsibility for their own learning and for the cohesiveness of their group finds himself caught between the dependent sub-group's demands for "firmer leadership," the rising attacks of the anti-dependents (see below) and his own image of how the group can mature with increased freedom to direct themselves.

REVOLT OF THE ANTI-DEPENDENTS

Again borrowing from the insights given us by Bion, Thelen, Cartwright and Zander (3) and others—confirmed by our own experience with such training courses—we know that some individuals come to the group with the feeling, conscious or unconscious, that "only by depending on our-

selves (not the leader) and by letting the group run itself will I get what I want out of this course." This sub-group is usually quiet at first, sizing things up. As opportunities for participation arise they become active in proposing their ideas, their methods and their agenda, sometimes in opposition to the leader's approach.

Our studies have shown that as pre-training course expectations are thwarted and dependency needs are frustrated members shift from the sub-group of dependents and become recruits for the rising sub-group of anti-dependents. These are called anti-dependent (not independent) because they have little or no real program to meet the total group's needs and are mainly *against* the present leadership. They express their views with comments such as: "The leader is too controlling. . . . He doesn't listen to the group. . . . If I were leading I'd never have. . . ." As these feelings gather momentum and as the nominal leader creates opportunities for participation this sub-group pushes forward emerging leaders who often try to take over. Usually they ride high, then fall—fall because they too cannot meet all the expectations and demands various members are placing on them and because they are not truly group-centered but only protesters. All this drama takes place masked behind the topics being discussed in our discussion-leader training course.

Where is the nominal leader in all this? He is caught between the extremes of the sub-groups with the dependents demanding more leadership, the anti-dependents demanding less. Confusion, frustration, bewilderment, anxiety and anger are brought to him by various members to be alleviated; he sees others evading, shrinking or even preparing to go home. In short, by providing the setting for the growth of a group, the leader has helped create a situation where it appears he is failing everybody—and everybody is telling him so either verbally or non-verbally. Despite Bion's reassurance that these feelings are directed against the traits of leadership (not against the leader) the leader nevertheless experiences a hostility or rejection that can seem real, personal and threatening. At this point our fictitious discussion-leader training course seems on the point of failure. During this stage only the leader's firm belief in people and in the group, his knowledge that this is a normal stage of growth, like adolescence, and his calm insistence that the group must solve its problems of polarization help him face the risks of dethronement and loss of prestige.

THE FALSE SOLUTIONS

This power struggle between the dependent faction and the anti-dependent faction puts the leader in the position of being damned if he leads or damned if he doesn't. He is thus often perceived as having failed at leadership. Now, however, as the protest leaders of the anti-dependent faction also begin to fail to meet group needs, anxiety begins to mount in the members of the group. To meet this anxiety some assume that the group must heal itself. Thelen points out that one group may quietly adopt a code of politeness and then pour its energies into being productive. Bion notes that another may have a fling at being independent by ignoring the leader who failed and trying to function without him, while its participants repress anxious feelings and take flight in busy work.

Basically these are false solutions. The rigid politeness covers up differences that still exist, feelings that cannot really be expressed. Relationships between participants tend to be stilted and stiff. Often big work plans are made and then collapse be-

cause no one really wants to carry them out. Some members begin to feel guilty and say that "we are not using the leader." Gradually the false politeness breaks down and the attempt at independence from leadership fails.

The group now begins to see the need for emotional honesty and real relationships, for staff and group togetherness and the services of the leader. The independent trait of ignoring the nominal leader gradually changes to interdependence with him. This becomes an interdependence of equals where the members can independently think and choose in what way to use the leader as a resource. Slowly the members begin to show more concern for one another and less of a tendency to demand that everyone conform to one group standard. Differences are tolerated, encouraged and explored. Ideas are combined as members help one another work out ideas. Again all this happens masked behind the topics being talked about. Much of it happens at lunch, in bull sessions or during impromptu parties at night. In reality our mental health discussion-leaders training course has had two agendas: (1) the content agenda of the topics talked about and (2) the experiential agenda of the participants as they learn to relate to one another in a group setting.

Perhaps this struggle to relate to leadership and to the leader himself would end happily with the group's growth to interdependence, but unfortunately not all new members reach this level of group interaction. As part of the debris of the struggle there are those casualties who are caught with their feelings arrested at the dependency, anti-dependency or independency levels of the group's maturation. Even when our mental health discussion-leader training course is over some members will go home saying:

The dependents: "The program wasn't organized enough. . . . We needed more content. . . . The leader was weak. . . . He let things get out of control. . . . He allowed too much anxiety. . . . Next time let's have a planned agenda, more experts, more lectures."

The anti-dependents: "Boy, was the leader manipulative. . . . We tried to rescue the situation but he blocked us. . . . He wouldn't let the group run itself. . . . He was autocratic."

Those who gave up depending on the group: "I didn't get anything out of the group or from the leaders. . . . I paired up with Mr. X and he helped me. . . . That group was too much for me. . . . I wasted my time. . . . There was too much anxiety to learn anything."

It would be ideal if all members of a group worked through to a new interdependent relationship with the nominal leader. This, however, is like hoping that all adolescents will work through to a new adult relationship with their parents in a companionship of equals. Regrettably, all adolescents don't. Some go on being dependent, rebellious or actively independent of their parents. Similarly, some in the group will continue chagrined, frustrated, resentful and suspicious of the leader. The publicity and reports they give back home about the course and the leader will be colored by (a) their frustrated pre-course expectations, (b) their pre-course images of the leader, and (c) the anxiety they experienced as the group struggled from comfortable dependence on the leader through the stages of self-discovery to the sense of responsibility that is required to build a mature group. In addition, it is inevitable that a leader—in the complexities of group, interpersonal and learning

processes—will make some genuine mistakes. This, added to the difficulties listed above that result from the process of group maturation, makes it even more understandable that providing freedom-giving leadership to groups involves some calculable risks.

IS IT WORTH THE RISKS?

Lest the preceding presentation become a provocation for abandoning the leadership effort instead of depicting it as an enjoyable rendezvous with reality, it might be well to examine the positive gains of freedom-giving leadership. Such leadership can contribute positive values not only to the group but also to the leader. One can say incisively that it creates a laboratory for human growth, a chance to find for oneself but in concert with others some of the deeper and more meaningful social realities.

A mature group becomes the most sensitive instrument to study human nature that we know. To lead such a group, however, is to expose one's self to intensive study. Each group makes a searching examination of its leader, of his intent, his strengths and his weaknesses. Although some members will use these findings to tell others about the leader, it has been our experience that more members will use their insights to move toward him with understanding and the intent to help. If a leader is ready, his experience with a group can become a mirror in which he learns more about his social impact on others and the quality of his own interpersonal relationships. The feedback he gets not only gives him insight into those areas in which he needs to grow, but often reconfirms his belief that there are many people who basically care about others. Even more meaningful is the discovery that much of this caring is not just the "protecting-you-to-protect-my-own-skin" kind of love but the firm, reality-facing concern for others that is rooted in the conviction that *all individuals can grow.*

In addition to the potentials for personal growth that freedom-giving group leadership can provide, the experience becomes a laboratory in which to test some of the basic beliefs or assumptions underlying much of our work with human personality. Some of these assumptions can never be fully proved but we need to test them to reconfirm our belief in them.

For instance, why should we break away from our culture's mode of safe, peaceful, leader-dependent groups? Is the risk worth it? Why go uphill against the participants' expectations that you will meet their needs? When you begin to answer these questions you find yourself going back to your basic assumptions—to your beliefs about people and groups. For example, to the belief that each group has the capacity to mature, to eventually direct itself and build an agenda superior to any a leader can give it. Behind this there are two beliefs even more fundamental: the belief that there is a basic tendency in people toward healthy growth and the belief that most people have the capacity to work out their own growth and the right to determine for themselves the direction of that growth.

Beyond these basic assumptions is the premise that individuals grow more and learn better in groups that are member-directed, free from dependence on the leader and conducive to interdependent relationships. This has been scientifically demonstrated in a number of situations.

Each group that struggles through to maturity is a living demonstration, a live test of these basic assumptions and premises. In our own experience, despite the risks involved and the pain of growing, these values have been confirmed again and

again. Each confirmation reinforces our philosophy and builds in us a greater willingness to face the risks of leadership because we are confident it is worthwhile.

As the leader begins to discover for himself the tremendous potentials of free groups to help him grow in sensitivity and self-understanding, his fear of the risks and the mistakes he will make begins to weigh less heavily on him. As these experiences deepen his social insights and strengthen his basic beliefs in the values of the mature democratic group process, the inevitable criticisms he will provoke assume smaller proportions. He will see the frustrations and disappointments as part of the process of group growth—a growth not unlike that of children in a family. Just as the best of parents have their periods of inadequacy, anxiety and feeling lost, so the group leader will experience these too. Just as children try to tangle their parents in dependent bids for help, in negativism or rebellion, so the group leader will be faced by a comparable drama of relationships. But just as it is a worthwhile goal of parenthood to help children develop into adult personalities mature enough to think, cooperate and relate wholesomely, so the development of a group that can think additively, use differences in individual members as strengths and operate interdependently is an objective worth attaining and worth any leadership risks involved.

REFERENCES

1. W. R. Bion, "Experiences in Groups 1, 2, 3, 4, 5," *Human Relations,* Vols. 1–3, London, Tavistock Publications, 1947–49.

2. H. A. Thelen and W. Dickerman, "Stereotypes and the Growth of Groups," *Educational Leadership,* 6(1949), 309.

3. Dorwin Cartwright and Alvin Zander, *Group Dynamics: Research and Theory,* Evanston, Ill., Row, Peterson, 1953.

MAX HAYMAN, M.D.

A unique day therapy center for psychiatric patients

In November 1955 a day therapy center was opened within the main focus of psychiatric activity in the Los Angeles area. It was established as an integral part of a large private sanitarium 15 miles and 45 minutes away from the city itself. The sanitarium staff, formerly resident only, was expanded to include an attending staff. The center's goal was to enable psychiatrists and psychoanalysts in the urban area nearby to provide adjunctive services or sanitarium care for their patients without time-consuming visits to the sanitarium. The day therapy center was therefore designed to provide assistance in the treatment of any patient who needed something more than office care.

Accordingly, the following types of patients were provided for:

1. Out-patients who lived at home and did not require sanitarium care but were psychotic, borderline, convalescent or severely neurotic. These could not be productively employed but were capable of selected activities.

2. In-patients of the sanitarium who could be brought to the therapy center daily or as often as the doctor made appointments for them. They could have a full prescribed program of therapeutic activities. By doctor's order they could be brought to the day therapy center and then taken to the beauty parlor, on shopping trips and to the movies or other activities.

3. Out-patients who required somatic therapies. Available at the center were electroshock, antabuse and various drug therapies.

The uniqueness of this day hospital setting lies in a number of factors: It is located in the neighborhood of a large medical community. It provides service to a large

Dr. Hayman is on the staff of the Compton Sanitarium and the Beverly-Compton Day Therapy Center in Beverly Hills, Calif.

attending psychiatric staff. By its physical proximity it "brings the sanitarium to the city." Because of these factors it provides a valuable mutual interaction of sanitarium, day therapy center and resident staff on the one hand and attending psychiatric staff on the other. Accordingly, it prevents the all too frequent isolation of the psychiatric hospital from the community it serves and at the same time extends to the attending psychiatric staff its therapeutic resources.

THE DAY HOSPITAL CONCEPT

The day hospital concept, originated essentially by Cameron (1, 2, 3) in 1946 and adopted shortly thereafter by the Menninger Foundation (4), is taking its place in the evolution of psychiatric treatment. Other experiments are being pursued, notably by Rees (5, 6), Jones (7, 8), and Bierer (9) in England, which are related to this and which emphasize the social and group aspects of therapy. In the last 25 years there has been a remarkable development in treatment methods, which has limited the usefulness of the standard psychiatric hospital and has stimulated the formation of new procedures and techniques. These developments have followed two paths—the physiological and the psychological. Insulin shock therapy, while almost extinct or at least much less common as a method of treatment today, intensified a search for physiological methods of treatment. This was followed by electroshock therapy which —since it became an out-patient procedure —stimulated the idea of the day hospital. The feasibility of ambulatory insulin therapy, which could also be carried out on an out-patient basis, also became apparent. The most recent era of tranquilizing drugs has still further eliminated the need for hospitalizing many patients.

Concurrent with this there has been an extension of the field of effort in psychodynamics and psychoanalysis. During these last 25 years there has also been considerable additional research into and understanding of ego psychology, permitting the psychotherapeutic treatment of borderline cases and overt psychotic patients. This development in turn stimulated and made necessary the development of attitude and *milieu* therapy. These changes in dynamic therapy were concurrent with and perhaps have been an outgrowth of change in the types of psychiatric illness. This change, as noted by an increasing number of psychiatrists, has been an increase in borderline states and character disorders. Fenichel (10) attributed the change to the need for character defenses against unpredictable teaching and disciplinary regimes. A particularly important factor in the unpredictability has been the alternation between over-indulgence and over-strictness. Misinterpretation of psychoanalytic findings may indeed have influenced an over-indulgence in the upbringing of children. For example, there was the belief that since inhibitions cause trouble one must get rid of all inhibitions. When this approach brought its inevitable problems, harsh and punitive methods were often applied as a corrective.

The basic therapy used with borderline states is psychotherapy but additional techniques often make the difference between success and failure in treatment. These techniques include adjunctive therapies, which are valuable and may sometimes be vital; distribution of roles between administrator and therapist, which may be necessary in certain instances (11); use of somatic therapies concurrent with psychotherapy; and providing the means for minimizing acting-out and for directing pathological impulses into more normal channels.

A day therapy center is ideal in this respect because it offers services to private practicing psychiatrists that are usually available only in a hospital or sanitarium. The patients of the day therapy center, in addition to borderline states, seem to be drawn in part from the neurotic group with severe character problems, in part from the psychotic group, many of whom are now accessible to psychotherapy. We must note too that often psychotic patients can be successfully treated because we are not so frightened of them as before.

ROLE OF THE PERSONNEL

The role of the day therapy center's personnel is, of course, vital. Cameron emphasized group integration with responsibility accepted by the group. He emphasized the need for training personnel in psychodynamics, manipulation of interpersonal relations and observation of patients. This is also an important part of our work at the center. So far, however, the development here has been more in terms of close personal relationships between individual patients and staff members. The ratio of patients to staff permits these relationships to develop. They are based on the individual patient's spontaneous selection of a staff member, who need not be the technical leader. In our teaching of personnel, we emphasize understanding and acceptance or rejection (depending on the attitude prescription) of the patient's defensive symptoms and maneuvers. The ultimate goal of the program is to make these defensive symptoms unnecessary to the patient insofar as possible, to relieve specific tensions and strains and to permit the discharge of specific impulses by specific therapeutic prescriptions.

Our arrangements were purposely made flexible so that the program could develop in a spontaneous manner. There has been no jelling as yet but we have noticed a few developments. The aides, besides assisting in some somatic procedures, have had especially close contact with one or more patients. The personal relationships which develop must be observed closely lest they develop too much anxiety in either the patient or the aide.

It is planned that the social worker be used for group activities and for the observation of group dynamics. The nurse in our center is primarily occupied with somatic treatments and has a rather restricted role in the therapeutic *milieu*. The occupational therapist, on the other hand, must be the hub of the activities program. She governs the *milieu* and directs the ancillary and auxiliary personnel. The role of the receptionist, we have found, is an extremely important one because she has the first contact with the usually diffident and helpless patient. Her most important task is to make the patient feel at home as quickly as possible and to help integrate him into the group. The psychological test program is still not fully worked out. Thus far we have tentatively selected the simplest tests that will give some information about the patient's emotional and intellectual functioning and an inventory of his interests. These include Serial Sevens, the Cornell Index, the Shipley-Hartford test and the Lee-Thorpe Interest Inventory. Others are specifically ordered as required.

Each patient is under the care of a psychiatrist in the area. We receive from the referring psychiatrist a clinical summary of the patient's diagnosis, psychiatric status and therapeutic needs. We also receive a checklist of the activities prescribed by the psychiatrist and his suggestions for treatment. We have found, however, that we cannot presume too much on the time of the psychotherapist for his help in planning

the therapeutic program for the patient, and we have tried to restrict demands in this respect. Since personal contact with the therapist is most valuable, we try to arrange for this whenever feasible. In any case we send a written report to the therapist at regular intervals which can be corrected, added to or criticized.

Initially every patient is discussed in a staff conference with the whole staff participating, and a program is planned. In regular conferences thereafter problems of transference and counter-transference occupy a good part of the discussions.

The director of the center maintains adequate records in conformity with the standards set for the residency training. He also carries on somatic therapies when requested by the attending staff.

THE CENTER IN OPERATION

The keynote in the center's physical arrangement is comfort and relaxation, with no institutional atmosphere. The reception room, except for the business office, is decorated as a living room. There is a den which is used as a card room and television room and the patients usually get together to have lunch there. Sanitarium patients have their lunches brought in from the sanitarium. Out-patients bring their own lunches and are served hot drinks. The mid-morning and mid-afternoon "coffee break" which has strong oral connotations for the patients helps keep the group spirit alive and functioning.

The patients come to the center from one to five days a week, the frequency being kept very flexible. The sanitarium patients are brought to the center in a group; out-patients provide their own transportation to and from the center.

The daily program begins at 9 a.m. and continues until 4:30 p.m., Monday through Friday. The center makes its consultation rooms available for psychotherapy to its attending staff members; or, where it is feasible, patients are taken to the doctor's office.

Assaultive or suicidal patients are accepted only for full sanitarium care. On improving, however, they are brought to the center each day from the sanitarium as indicated or they may be transferred to the out-patient program.

FLEXIBILITY IN SERVICES

The center as an adjunct to a sanitarium has many advantages. In those cases where the condition of patients who enter the center regresses to the point of extreme disturbance they have been transferred to the sanitarium. On the other hand, patients have been able to leave the sanitarium sooner by being transferred during convalescence to the day therapy center. In this way, hospitalization has been reduced, there has been a more rapid turnover of patients and costs have been cut. Certainly many more patients are accessible to treatment by psychotherapists in their offices as a result of the services available at the day therapy center.

The day therapy center, being in an urban setting, has unlimited opportunities for instituting new services. It can utilize psychiatrists with specialized skills to carry on group psychotherapy and psychodrama, and ancillary personnel for various activities such as gymnasium, dancing and social clubs. These resources are all being called on as the need develops.

CONCLUSION

In summary, we believe the day hospital idea will probably expand, spread to various centers in the country, bring psychiatric

hospitals and sanitaria closer to the community and replace many archaic methods in the treatment and management of psychiatric patients.

Our own day therapy center represents an experimental attack, both lay and medical, on psychiatric illness within the community itself. If the day therapy center meets the needs of our community, the experiment will succeed.

REFERENCES

1. D. E. Cameron, "Day Hospital; Experimental Form of Hospitalization for Psychiatric Patients," *Modern Hospital,* 69(Sept. 1947), 60.

2. D. E. Cameron, "Open Psychiatric Hospital," *Modern Hospital,* 74(Feb. 1950), 84.

3. D. E. Cameron, "The Day Hospital," in *The Practice of Psychiatry in General Hospitals,* by A. E. Bennett and others, Berkeley, University of California Press, 1956.

4. R. I. Barnard, L. L. Robbins and F. M. Tetzlaff, "Day Hospital as Extension of Psychiatric Treatment," *Bulletin of the Menninger Clinic,* 16(March 1952), 50.

5. J. R. Rees, "Diagnosis and Prophylaxis in Psychiatry at Home and Abroad," *American Journal of Psychiatry,* 107(Aug. 1950), 81.

6. J. R. Rees, "Role of Psychiatry and Social Sciences in World Affairs," *Psychiatry,* 15(Feb. 1952), 1.

7. A. A. Baker, M. Jones, J. Merry, B. A. Pomryn, "A Community Method of Psychotherapy," *British Journal of Medical Psychology,* 26(1953), 222.

8. M. S. Jones and R. N. Rapoport, "Administrative and Social Psychiatry," *Lancet,* 269(Aug. 20, 1955), 386.

9. J. Bierer, *The Day Hospital,* London, H. K. Lewis & Co., 1951.

10. O. Fenichel, *The Psychoanalytic Theory of Neurosis,* New York, W. W. Norton & Company, 1945.

11. D. M. Bullard, "Problems of Clinical Administration," *Bulletin of the Menninger Clinic,* 16(Nov. 1952), 193.

BENJAMIN MALZBERG, PH.D.

Cohort studies of mental disease in New York State: 1943 to 1949

PART V. SENILE PSYCHOSES

The number of first admissions with senile psychoses to the New York civil state hospitals has been increasing for many years. In 1920 there were 646 such first admissions, representing 9.8% of the total first admissions that year. Thirty years later this number had grown to 2,439, or 15.2% of the total first admissions. This was not due to the growth of the general population of New York State, because the rate of first admissions with senile psychoses per 100,000 population increased from 6.2 in 1920 to 15.4 in 1950. Neither did it result from a disproportionate increase in the aged element of the general population. If we consider those aged 70 or over as representing the senile group, their rate of first admissions increased from 216 per 100,000 in 1920 to 568 in 1950. Since previous studies have all shown that rates of discharge decrease to a minimum among the oldest groups of admissions to mental hospitals and that rates of mortality advance to a maximum in such groups, it is obvious that the increase of the senile psychoses must have a deleterious influence upon the average results of treatment in the New York civil state hospitals.

This study of the results of such treatment is based upon five successive annual cohorts of first admissions with senile psychoses to the New York civil state hospitals. The first cohort was drawn from admissions during the fiscal year 1943–44. The fifth cohort was drawn from admissions during the fiscal year 1947–48. The total for the five annual groups was 10,666. This is 239 less than the total first admissions with senile psychoses during the same period. The difference resulted from the fact that first admissions who had left the state hospital system by transfer to other mental hospitals or who were readmitted to these other hospitals were not in the five cohorts.

Dr. Malzberg was formerly the director of statistics for the New York State Department of Mental Hygiene. These are the 5th and 6th of a series of 9 reports based on an investigation supported by a research grant from the National Institute of Mental Health.

The age distribution of the 10,666 first admissions is shown in Table II. There were only 48 who were under age 60 at the time of admission, representing premature cases of senility. Those aged less than 70 included only 12% of the total. Almost 90% were therefore over 70 years of age at the time of admission, a fact which will be shown to have an important effect upon the subsequent movement of the patients. Although the number of first admissions declined after ages 75 to 79 it is significant

TABLE I

First admissions with senile psychoses to New York civil state hospitals, fiscal years 1943–44 to 1947–48 inclusive

FISCAL YEAR	MALES	FEMALES	TOTAL
1943–1944	898	1,353	2,251
1944–1945	849	1,133	1,982
1945–1946	840	1,326	2,166
1946–1947	783	1,289	2,072
1947–1948	839	1,356	2,195
Total	4,209	6,457	10,666

TABLE II

First admissions with senile psychoses to New York civil state hospitals, fiscal years 1943–44 to 1947–48 inclusive, classified according to age

	NUMBER			PERCENT		
AGE (*years*)	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
Under 60	16	32	48	0.4	0.4	0.4
60–64	120	205	325	2.9	3.2	3.1
65–69	334	574	908	7.9	8.9	8.5
70–74	908	1,302	2,210	21.6	20.2	20.7
75–79	1,123	1,577	2,700	26.7	24.4	25.3
80–84	948	1,582	2,530	22.5	24.5	23.7
85–89	576	848	1,424	13.7	13.1	13.4
90 or over	171	314	485	4.1	4.9	4.5
Unascertained	13	23	36	0.3	0.4	0.3
Total	4,209	6,457	10,666	100.0	100.0	100.0

that the rate per 100,000 corresponding population increased to a maximum among the oldest age groups.

Discharges are summarized in Table III. The percentages and rates of discharge during the first year after hospitalization were based upon the experience of all five cohorts, since all the cohorts were observed for at least a year after admission. The fifth cohort had an exposure of only one year, hence it could not be included with the discharges of the second and subsequent years. Consequently the percent and rate of discharge during the second year are based upon the experience of the first four cohorts. Following this procedure, it will be evident that only one cohort, that of 1943–44, was exposed for the full five years. Hence this cohort furnished the basis for the experience of the fifth year.

As might have been expected, the level of discharge was very low. Only 5.9% of the male cohorts with senile psychoses were discharged within five years after hospitalization. The corresponding percentage for male first admissions with psychoses with cerebral arteriosclerosis was 15.6. The percentage for all male first admission was 42.0. Only 2.3% of the senile psychotics were discharged during the first year after hospitalization, most being discharged within three months after admission. An additional 2.8% were discharged during the second year. Only 0.8% more were discharged during the remaining three years. About 5% of all those discharged from the books had left the hospitals during the first year, either by direct discharge or by placement in convalescent care.

Of the female cohorts 6.1% had been dis-

TABLE III

First admissions with senile psychoses to New York civil state hospitals discharged during specified periods after admission, classified according to percentage and rate

PERIOD OF HOSPITALIZATION	MALES			FEMALES		
	Percent	*Cumulative percent*	*Rate per 1,000 exposures* *	*Percent*	*Cumulative percent*	*Rate per 1,000 exposures* *
First three months	1.5	1.5	95.2	1.6	1.6	93.0
Second three months	0.3	1.8	25.9	0.2	1.8	12.1
Third three months	0.3	2.1	27.9	0.1	1.9	7.6
Fourth three months	0.2	2.3	23.8	0.3	2.2	26.6
First year	2.3	2.3	33.5	2.2	2.2	30.4
Second year	2.8	5.1	94.5	3.0	5.2	78.8
Third year	0.4	5.5	25.4	0.6	5.8	24.4
Fourth year	0.4	5.9	33.6	0.2	6.0	9.4
Fifth year	–	5.9	–	0.1	6.1	5.8

* On an annual basis.

charged within five years after admission, compared with 17.2% of female first admissions with psychoses with cerebral arteriosclerosis and 43.5% of all female first admissions. Within three months after admission 1.6% had been discharged. This grew to 2.2% for the entire first year. An additional 3% were discharged during the second year. Only 0.9% were discharged during the three following years. As with the males, about 5% of the cohort had left the hospitals during the first year, either by direct discharge or by placement in convalescent care.

As with first admissions suffering psychoses with cerebral arteriosclerosis, discharges were low among senile psychotics, compared with corresponding discharges among a cohort of senile psychotics admitted to the New York civil state hospitals during 1909–10.[1] Readmissions and placement in convalescent care were both low; therefore it is proper to compare results at the end of the first year of hospitalization. At that point 10.3% of the early male cohort had been discharged, compared with only 2.3% of the current male cohorts. At the end of the second year the corresponding percentages were 11.5 and 5.1 respectively. At the end of the fifth year they were 12.7 and 5.9 respectively.

Comparisons of the female cohorts lead to the same results, though the differences were much smaller.[2] At the end of the first year the percentages discharged were 5.7 and 2.2 for the early and current female cohorts respectively. At the end of the second year they were 7.2 and 5.2 respectively. At the end of the fifth year they were 8.7 and 6.1 respectively.

Rates of discharge per 1,000 annual exposures were as follows: The male cohorts were discharged during the first three months at an annual rate of 95.2. The rate fell during the remainder of the year and averaged 33.5 for the first year. It rose to 94.5 per 1,000 exposures during the second year, then declined to 25.4 during the third year and to 33.6 during the fourth year. There were no discharges during the fifth year.

The female cohorts had lower rates of discharge than males. They began with a rate of 93.0 per 1,000 annual exposures during the first three months and declined to an average of 30.4 for the first year. The rate rose to 78.8 during the second year, compared with 94.5 for males. The rate declined to 5.8 during the fifth year.

During the two crucial years following admission the current male cohorts had a discharge rate of 80.9 per 1,000 exposures, compared with 170.2 [3] for the male cohort of 1909–10. For females the corresponding rates were 78.5 and 99.1 respectively.

It is clear that rates of discharge among first admissions with senile psychoses have not increased over several decades. It is sometimes stated that such comparisons are not valid because standards of diagnosis may have changed. Such differences, if they are real, would apply to differential diagnoses as between senile psychoses and psychoses with cerebral arteriosclerosis. But it was shown in the previous chapter that discharge rates among first admissions with psychoses with cerebral arteriosclerosis had also failed to increase over a period of 40 years. Therefore the rates of discharge resulting from the combination of the two groups of mental disorders must also show

---

[1] Raymond G. Fuller, "Expectation of Hospital Life and Outcome for Mental Patients on First Admission," *Psychiatric Quarterly*, 4(April 1930), 312.

[2] *Loc. cit.*

[3] Rates of discharge computed from data in reference 1, 312.

differences in the same direction. In fact, when combinations of these groups of psychoses are compared with respect to discharges within five years after admission, the results were as follows: current male cohorts, 12.0%; early male cohort, 15.7%. Among females the corresponding percentages were 13.1 and 11.0 respectively. The latter does not represent a significant difference. We must conclude therefore that current first admissions with psychoses associated with advanced age do not respond to treatment any better than similar groups of an earlier epoch.

Rates of discharge among males per 1,000 annual exposures varied inversely in accordance with increasing age at first admission (Table IV). Those aged less than 70 years at admission had a discharge rate of over 100 per 1,000 annual exposures during

TABLE IV

*Rates of discharge * among first admissions with senile psychoses to New York civil state hospitals during specified periods after admission, classified according to age at first admission*

AGE AT FIRST ADMISSION (*years*)	*1st three mos.*†	*2nd three mos.*†	*3rd three mos.*†	*4th three mos.*†	*1st year*	*2nd year*	*3rd year*	*4th year*	*5th year*
					MALES				
Under 60	–	–	–	–	–	166.7	–	–	–
60–64	84.5	–	–	–	21.4	105.3	35.1	57.1	–
65–69	81.1	19.2	20.6	–	26.8	134.4	54.5	39.2	–
70–74	87.8	31.1	70.7	10.0	40.7	99.4	14.7	28.8	–
75–79	97.4	15.2	17.6	49.4	33.7	89.7	17.4	22.4	–
80–84	106.7	49.3	12.0	28.7	37.1	87.2	11.4	57.1	–
85–89	76.6	18.6	–	28.6	22.2	49.4	26.0	–	–
90 or over	216.6	–	–	–	39.0	66.7	133.3	–	–
					FEMALES				
Under 60	272.4	170.2	–	190.4	142.9	71.4	–	142.9	–
60–64	134.9	–	–	–	33.9	140.8	35.4	–	–
65–69	51.2	–	–	22.4	17.1	113.4	51.1	29.6	–
70–74	70.1	9.8	5.4	29.9	25.2	85.0	32.4	8.7	20.4
75–79	121.6	4.4	15.0	44.2	40.3	61.7	5.0	–	–
80–84	82.8	19.9	59.9	–	24.7	60.6	25.2	–	–
85–89	111.1	30.8	12.8	44.7	39.8	62.7	–	–	–
90 or over	67.3	–	–	–	15.7	75.0	–	–	–

* Per 1,000 annual exposures

† On an annual basis

the second year of hospitalization. After age 70 the discharge rate dropped during this period of hospitalization to less than 70. The same trend was repeated in subsequent years of hospitalization.

There were fluctuations in rates of discharge among the female cohorts, but in general the rates during each period of hospitalization became less as the age at first admission decreased.

TABLE V

Discharges among first admissions with senile psychoses to New York civil state hospitals, fiscal years 1943–44 to 1946–47 inclusive, within two years after admission, classified according to condition at discharge

CONDITION AT DISCHARGE	MALES			FEMALES			TOTAL		
	Number	*Percent of total discharges*	*Percent of first admissions*	*Number*	*Percent of total discharges*	*Percent of first admissions*	*Number*	*Percent of total discharges*	*Percent of first admissions*
Recovered	21	12.1	0.6	33	12.3	0.6	54	12.2	0.6
Much improved	44	25.4	1.3	63	23.5	1.2	107	24.3	1.3
Improved	73	42.2	2.2	118	44.0	2.3	191	43.3	2.3
Unimproved	35	20.2	1.0	54	20.1	1.1	89	20.2	1.1
Total discharges	173	100.0	5.1	268	100.0	5.3	441	100.0	5.2
Total first admissions	3,370	–	–	5,101	–	–	8,471	–	–

Table V shows the condition of those patients discharged within two years after admission. This period was selected because 90% of the discharges occurred within these two years. Furthermore, the cohort of 1947–48 had to be excluded since its period of exposure was one year only.

There were 8,471 first admissions with senile psychoses among the first four cohorts, of whom only 54, or 0.6%, were discharged as recovered. In addition, 3.6% were discharged as improved. There was no sex difference in this respect.

This may be compared with corresponding percentages for the cohort of 1909–10.[4] Of the latter 6.6% were discharged with some degree of improvement, including recovery, within two years after admission, compared with 4.2% of the current cohorts. For males the corresponding percentages were 8.2 and 4.1 respectively. For females they were 5.1 and 4.1 respectively.

To eliminate possible biases with respect to differential diagnoses it is desirable to present similar percentages of improve-

[4] Raymond G. Fuller, "Hospital Departures and Readmissions among Mental Patients during the Fifteen Years Following First Admission," *Psychiatric Quarterly*, 4(October 1930), 655.

ment for combined cohorts of first admissions with senile psychoses and psychoses with cerebral arteriosclerosis. On this basis the percentages of improvement for males were as follows: current cohorts, 9.4; early cohorts, 10.5. For females the corresponding percentages were 10.4 and 7.9. There is evidence of a slight improvement among females but none among males.

Thus it appears that the current cohorts of first admission with senile psychoses not only had lower rates of discharge than the early cohort, but rates of improvement were also less. We must infer that today patients admitted with senile psychoses come, as do those with psychoses with cerebral arteriosclerosis, from a population of advanced age which is not selected as rigorously as that of the earlier generation who reached these age periods and consequently do not respond as well to known types of therapy.

MORTALITY

If discharges were relatively low among first admissions with senile psychoses, mortality was correspondingly high. An average of 83.6% of the male cohorts died within five years after admission to the hospitals. This may be compared with 72.1% for male first admissions with psychoses with cerebral arteriosclerosis and 39.0% for all male first admissions. Mortality was heaviest during the first year after admission, three-fourths of all the deaths occurring during this period. Within the first year the crucial period was the first three months. Mortality decreased rapidly after the first year.

TABLE VI

First admissions with senile psychoses to New York civil state hospitals dying during specified periods after admission, classified according to percentage and rate

PERIOD OF HOSPITALIZATION	MALES			FEMALES		
	Per-cent	*Cumula-tive percent*	*Rate per 1,000 exposures* *	*Per-cent*	*Cumula-tive percent*	*Rate per 1,000 exposures* *
First three months	42.4	42.4	(1,000.0)	32.9	32.9	(1,000.0)
Second three months	9.6	52.0	687.4	10.4	43.3	640.9
Third three months	6.1	58.1	533.4	6.7	50.0	488.6
Fourth three months	4.3	62.4	436.7	4.4	54.4	371.8
First year	62.4	62.4	631.7	54.4	54.4	550.6
Second year	9.3	71.7	285.3	12.0	66.4	285.6
Third year	5.6	77.3	267.2	6.2	72.6	236.6
Fourth year	3.6	80.9	266.4	4.3	76.9	222.2
Fifth year	2.7	83.6	300.0	2.7	79.6	190.0

* On an annual basis.

Of the female cohorts an average of 79.6% died within five years after hospitalization. Of all female first admissions only 36.0% died within this period. The percentage rose to 70.0 among female first admissions with psychoses with cerebral arteriosclerosis. Most of the deaths (32.9% of the total admissions) occurred within three months after admission. Fifty-four percent of the female cohorts died during the first year, compared with 62% of the male cohorts.

Among a cohort of male first admissions with senile psychoses in 1909–10,[5] 77.3% died within five years after admission, compared with 83.6% of the later cohorts. The contrast was marked during the early months of hospitalization. During the first three months after admission 29.3% of the early cohort died, compared with 42.4% of the current cohorts. Within a year the corresponding percentages were 52.8 and 62.4 respectively.

For females the mortality during the first three months represented 20.5% of the total admissions among the early cohort, compared with 32.9% of the current female cohorts. By the end of the first year these had increased to 41.8 and 54.4% respectively. By the end of five years the percentages were 74.8 and 79.6 respectively.

Rates of mortality per 1,000 annual exposures were highest during the three months following admission. They decreased during the remainder of the first year and averaged 631.7 among the male cohorts. They decreased after the first year, though the rates were still relatively high. Among females the rate averaged 550.6 per 1,000 exposures during the first year of hospitalization. They declined in subsequent years to a minimum of 190.0 during the fifth year. During each yearly period females had lower death rates than males.

Compared to the cohorts of 1909–10,[6] the current rates of mortality were consistently higher. Thus at the end of the first year rates of mortality per 1,000 annual exposures were 557.1 for the early male cohort, compared with 631.7 for the current male cohorts. For females the comparable rates were 430.5 and 550.6 respectively. Taking the two years following admission as the crucial period, we obtain comparative death rates. For males, early cohort, 688.4; current cohort, 749.8. For females, early cohort, 573.9; current cohort, 679.4.

For reasons explained earlier, it is desirable to compare mortality for the two sets of cohorts based upon combinations of the senile and arteriosclerotic cohorts. On this basis we may present certain comparisons. Of the current male cohorts 76.3% died within five years, compared with 71.3% of the early male cohort. Among females the corresponding percentages were 73.5 and 72.0 respectively.

This strengthens the conclusion arrived at previously that the population of advanced age apparently has lesser powers of resistance than populations reaching the same age levels in an earlier generation.

As with other groups of mental disorders, rates of mortality were related directly to age at first admission. Even within the restricted age-range of the senile psychoses, rates of mortality rose as the age at first admission increased. Thus among males the mortality rate during the first year rose from 437.5 among those aged less than 60 at time of admission to 810.7 among those aged 90 or over. During the second year after admission the rates rose from under 200 to over 400. Because of the small

[5] See reference 1, 306.

[6] Rates of mortality computed from data in reference 1, 306.

population remaining after the second year the death rates fluctuated fortuitously during the remaining years. The trends were similar for females, the rates rising during the first year of hospitalization from 266 among those aged less than 60 to 787 among those aged 90 or over.

Primarily because of the high mortality the number remaining on the books was reduced very rapidly. By the end of the third month after admission only 56.1% of the males were still on the books. By the end of the first year only a little more than a third were still on the books. By the end of the fifth year the cohort had been reduced to 6.2%.

The female cohorts were also reduced rapidly, though they exceeded males be-

TABLE VII

*Rates of mortality * among first admissions with senile psychoses to New York civil state hospitals during specified periods after admission, classified according to age at first admission*

AGE AT FIRST ADMISSION (*years*)	*1st three mos.*†	*2nd three mos.*†	*3rd three mos.*†	*4th three mos.*†	*1st year*	*2nd year*	*3rd year*	*4th year*	*5th year*
					MALES				
Under 60	(1000.0)	333.3	727.3	–	437.5	–	–	–	–
60–64	981.0	584.3	526.3	60.6	445.4	181.8	163.9	162.2	–
65–69	(1000.0)	403.3	235.2	229.2	441.8	224.0	260.2	245.6	428.6
70–74	(1000.0)	557.2	438.1	411.8	546.7	217.6	251.6	148.6	285.7
75–79	(1000.0)	698.7	495.8	417.6	633.3	307.4	280.3	342.9	384.6
80–84	(1000.0)	812.1	651.0	645.4	699.4	328.6	334.9	418.6	250.0
85–89	(1000.0)	936.4	932.0	534.6	755.2	435.6	252.9	352.9	555.6
90 or over	(1000.0)	(1000.0)	585.4	571.4	810.7	432.4	133.3	–	–
					FEMALES				
Under 60	396.7	612.6	181.8	–	266.7	36.4	–	–	–
60–64	620.8	190.4	175.0	261.4	277.2	123.2	150.0	129.0	71.4
65–69	844.0	455.4	221.7	235.8	377.2	211.4	164.9	152.8	148.1
70–74	(1000.0)	465.0	386.4	324.2	480.8	240.2	219.8	176.0	116.5
75–79	(1000.0)	633.1	460.8	350.5	529.8	317.6	253.8	252.4	256.4
80–84	(1000.0)	763.9	652.9	430.1	621.0	333.0	311.8	341.2	242.4
85–89	(1000.0)	878.0	752.4	507.7	675.0	365.1	277.1	285.7	133.3
90 or over	(1000.0)	(1000.0)	943.4	790.1	787.2	444.4	307.7	–	800.0

* Per 1,000 annual exposures

† On an annual basis

cause of their lower mortality. They were reduced to 65.4% of the original total by the end of three months, to 43.3% at the end of the first year, to 11.3 percent at the end of the fifth year. The median durations were 4.8 months for males and 5.2 months for females.

Of the cohorts of 1909–10,[7] 9.5% of the males and 15.5% of the females were still on the books after five years, including readmissions during this period. The corresponding percentages for the current cohorts were 7.9 and 11.6% respectively.

For combinations of first admissions with senile psychoses and psychoses with cerebral arteriosclerosis the results were as follows: 10.1% of the current male cohort and 10.3 of the early cohort remained on the books after five years. For females the corresponding percentages were 12.7 and 14.6 respectively. Thus the differences arising after a period of almost four decades are without statistical significance.

TABLE VIII

Percent of first admissions with senile psychoses to New York civil state hospitals remaining in continuous residence at the end of specified periods after admission

END OF	MALES	FEMALES
Third month	56.1	65.4
Sixth month	46.2	54.9
Ninth month	39.8	48.1
First year	35.3	43.3
Second year	21.8	28.6
Third year	15.0	19.9
Fourth year	9.7	14.8
Fifth year	6.2	11.3

SUMMARY

The histories of the five annual cohorts of first admissions with senile psychoses with respect to duration of hospitalization may be summarized as follows. These cohorts included 10,666 first admissions, of whom 4,209 were males and 6,457 were females. The periods of exposure varied from a maximum of five years for the cohort of 1943–44 to a minimum of one year for the cohort of 1947–48. These periods varied because, though they all had the same closing date, the dates of admission increased successively by a year from the first cohort to the last. Consequently discharges and mortality during specified periods are averages based upon the total annual exposures during each of these periods.

Of the males an average of 5.9% was discharged from the books during the five

[7] See reference 1, 301.

years. Few discharges occurred after the second year. The discharge rate was relatively high during the first three months and averaged 95.2 per 1,000 annual exposures for that period. The rate dropped during the remainder of the first year, averaging 33.5 for the year, and rose to 94.5 during the second year.

Of the females 6.1% were discharged during the five years, 85% of the discharges occurring during the first two years. The rate per 1,000 annual exposures was 93.0 for the first three months and averaged 30.4 for the first year. The rate rose to 78.8 during the second year.

When these cohorts are compared with a cohort of first admissions during 1909–10, the results are not favorable to the current groups. Thus of the recent male cohorts with senile psychoses 5.9% were discharged within five years, compared with 12.7% of the early cohort. For females the corresponding percentages were 6.1 and 8.7 respectively.

Comparisons with respect to condition at discharge show differences of the same kind. Thus 8.2% of the early male cohorts were discharged with some degree of improvement, compared with only 4.1% of the current cohorts. For females the corresponding percentages were 5.1 and 4.1 respectively.

Mortality was high. Thus an average of 83.6% of the male cohorts died within five years after hospitalization. Of the female cohorts 79.6% died within this period. The rate of mortality was highest during the three months following hospitalization and dropped steadily thereafter. Death rates were high in comparison with the early cohorts. Thus within the crucial period of the first two years the current male cohorts had a death rate of 749.8 per 1,000, compared with 688.4 for the early male cohort. For females the corresponding rates were 679.4 and 573.9 respectively.

As a consequence of the high mortality the cohorts were reduced in number very rapidly. Of the current male cohorts only 6.2% remained continuously on the books for five years. The corresponding percentage for females was 11.3. Both cohorts had shorter periods on the books than corresponding cohorts of 1909–10, resulting primarily from differences with respect to mortality.

It is frequently stated that statistical differences between senile psychoses and psychoses with cerebral arteriosclerosis arise from changes over the years with respect to differential diagnoses. One way of meeting this difficulty is to combine both categories into a single group. We then arrive at the following comparisons. Of the early male cohort 15.7% were discharged within five years, compared with 12.0% of the current male cohorts. Of the early group 10.5% were discharged with some degree of improvement, including recovery, compared with 9.4% of the current cohort. Of the early cohort 71.3% died within five years, compared with 76.3% of the recent cohorts. Thus it appears that male admissions of advanced age to the New York civil state hospitals show no improvements in outcome as compared with similar age groups admitted 40 years earlier. Similar comparisons for females show a slightly higher rate of discharge for the current cohorts and slightly higher death rates. These differences are not statistically significant and lead to the conclusion that there have been no substantial changes over the years with respect to outcome of treatment for these groups.

PART VI. INVOLUTIONAL PSYCHOSES

Next to dementia praecox and the psychoses associated with advanced age, first admissions with involutional psychoses to the New York civil state hospitals now represent the largest total of annual admissions. During the five fiscal years which began April 1, 1943 and ended March 31, 1948 there were 4,336 such first admissions, or 6.5% of the total. On the latter date patients with involutional psychoses represented 4.0% of the resident population. Not only do first admissions with involutional psychoses constitute one of the largest groups of mental patients, but for several decades they have been forming an ever-increasing percentage of the total admissions. Consequently rates of discharge and mortality among such patients have an important influence upon the over-all rates for all patients.

In this chapter we shall consider such rates among cohorts of first admissions with involutional psychoses to the New York civil state hospitals during five successive fiscal years beginning with the fiscal year 1943–1944.

Table IX shows the number of first admissions in each cohort. Except for a decrease during 1944–45, there was an increase from 807 in 1943–44 to a maximum of 890 in 1947–48.

Table X summarizes the distribution with respect to age. The cohorts were grouped closely within the limits of ages 45 and 59. Only 11.9% were less than 45, and 14.9% were 60 or over. The median age was 52.7 years. Females were younger than males at the time of first admission, the median ages being 51.7 and 55.4 years respectively. Fifteen percent of the females were less than 45 years of age, compared with only 4% of the males. On the other hand, 24.4% of the males were 60 or over, compared with only 11.1% of the females.

Table XI provides data with respect to discharges during specified periods after hospitalization.

Of the five male cohorts an average of 68.2% had been discharged from the books within five years after hospitalization. The average percent discharged during the first year was 9.6. The majority of the discharges within this period occurred during

TABLE IX

First admissions with involutional psychoses to New York civil state hospitals, fiscal years 1943–44 to 1947–48 inclusive

FISCAL YEAR	MALES	FEMALES	TOTAL
1943–1944	190	617	807
1944–1945	194	561	755
1945–1946	244	600	844
1946–1947	285	601	886
1947–1948	287	603	890
Total	1,200	2,982	4,182

TABLE X

First admissions with involutional psychoses to New York civil state hospitals, fiscal years 1943–44 to 1947–48 inclusive, classified according to age

AGE (*years*)	NUMBER			PERCENT		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*
Under 35	–	8	8	–	0.3	0.2
35–39	4	52	56	0.3	1.7	1.3
40–44	43	395	438	3.7	13.2	10.4
45–49	202	741	943	16.8	24.8	22.6
50–54	323	861	1,184	26.9	28.9	28.3
55–59	334	590	924	27.8	19.8	22.1
60–64	221	234	455	18.4	7.8	10.9
65 or over	72	97	169	6.0	3.3	4.0
Unascertained	1	4	5	0.1	0.1	0.1
Total	1,200	2,982	4,182	100.0	100.0	100.0

the first three months. Discharges were few during the remainder of the first year, but rose to 49.5% of the total admissions during the second year. Discharges during this year represented three-fourths of all discharges. The high percentage of discharge during the second year resulted from the termination of periods of placement in convalescent care. Of those discharged from the books during the second year 80% had been placed in convalescent care during the first year. Therefore it may be estimated that from 50 to 55% of the male cohorts left the hospitals during the first year, either by direct discharge or by placement in convalescent care.

The history of discharge was essentially the same for the female cohorts. Of these groups 69.6% were discharged within five years. Discharges were relatively high during the first three months but decreased during the remainder of the first year. Of the total female cohorts 10.8% were discharged during the first year. This rose to 46.9% during the second year, or two-thirds of all discharges. As with males, this resulted from termination of convalescent care during this period. About 80% of these placements had been made during the first year of hospitalization. Therefore approximately 50% of the females had left the hospitals within a year, either by direct discharge or by placement in convalescent care.

The percentage of discharges was almost 60% greater than that for all first admissions, three times greater than those for the senile and arteriosclerotic groups combined, twice that for general paretics and on a par with the percentage of discharges for the cohort of alcoholic psychoses. There are no studies of earlier cohorts with invo-

lutional psychoses and comparisons are therefore not available. It is certain, however, that the current rates of discharge must be higher in view of the introduction of convulsive types of therapy.

Table XI shows the average rates of discharge during specified periods after hospitalization per 1,000 annual exposures during each period. The rate for males was 258.9 during the first three months. It dropped rapidly during the remainder of the first year to 24.5 during the final quarter and averaged 100.6 for the first year. The rate rose to 623.9 during the second year as the result of discharge from convalescent care. The rate remained relatively high during the third year but dropped to a minimum of 35.7 during the fifth year.

The rate of discharge was higher for females than for males during the first year. It began with a rate of 297 during the first three months and averaged 112.1 for the first year. The rate rose during the second year to 585.3, which was less than that for males. The rates declined during the fourth and fifth years to a minimum of 61.4.

Analyses of previous groups of cohorts showed that rates of discharge tended to decline as the age at first admissions increased. Except for fluctuations resulting from small numbers, this inverse relation repeats itself in each period of hospitalization subsequent

TABLE XI

First admissions with involutional psychoses to New York civil state hospitals discharged during specified periods after admission, classified according to percentage and rate

PERIOD OF HOSPITALIZATION	MALES			FEMALES		
	Per-cent	*Cumula-tive percent*	*Rate per 1,000 exposures* *	*Per-cent*	*Cumula-tive percent*	*Rate per 1,000 exposures* *
First three months	6.2	6.2	258.9	7.1	7.1	297.0
Second three months	2.1	8.3	95.9	1.4	8.5	66.7
Third three months	0.8	9.1	40.0	1.3	9.8	60.4
Fourth three months	0.5	9.6	24.5	1.0	10.8	47.3
First year	9.6	9.6	100.6	10.8	10.8	112.1
Second year	49.5	59.1	623.9	46.9	57.7	585.3
Third year	7.0	66.1	242.4	6.8	64.5	211.0
Fourth year	1.6	67.7	77.4	3.7	68.2	143.1
Fifth year	0.5	68.2	35.7	1.4	69.6	61.4

* On an annual basis.

to admission. In the case of the male cohorts with involutional psychoses the trend in the first year is not too clear, although the rates are lower at the older ages (Table XII). During the second year, however, the large number of discharges stabilized the rates of discharge. It is then evident that the rates decreased steadily with advancing age. There was a similar trend during the third year after age 45.

Because female first admissions with involutional psychoses are in marked excess over males their rates of discharge are more stabilized and show fewer fluctuations from trend. Thus during the first three months of hospitalization the rates dropped by

TABLE XII

Rates of discharge among first admissions with involutional psychoses to New York civil state hospitals during specified periods after admission, classified according to age at first admission

AGE AT FIRST ADMISSION (*years*)	*1st three mos.*†	*2nd three mos.*†	*3rd three mos.*†	*4th three mos.*†	*1st year*	*2nd year*	*3rd year*	*4th year*	*5th year*
					MALES				
Under 35	–	–	–	–	–	–	–	–	–
35–39	–	–	–	–	–	1000.0	–	–	–
40–44	97.0	200.0	–	–	71.4	720.0	250.0	333.3	–
45–49	262.0	175.4	69.3	–	121.2	671.9	321.4	71.4	–
50–54	338.4	43.8	30.0	30.5	107.1	647.3	309.3	114.3	–
55–59	185.4	104.5	41.2	28.3	87.2	600.4	245.6	38.4	–
60–64	270.5	65.2	44.9	46.6	102.2	562.0	114.3	76.9	166.7
65 or over	325.2	76.4	–	–	93.8	579.7	125.0	–	–
					FEMALES				
Under 35	1000.0	–	–	–	250.0	500.0	–	1000.0	–
35–39	615.4	272.7	–	–	213.6	807.7	–	250.0	–
40–44	365.8	57.8	59.0	47.9	126.6	695.0	186.4	225.8	66.7
45–49	294.6	68.3	102.3	46.3	120.8	570.3	267.1	124.2	92.0
50–54	282.1	90.8	44.0	39.3	108.7	602.0	155.3	137.6	63.8
55–59	260.7	39.7	40.4	33.0	89.3	542.4	262.9	169.8	–
60–64	231.8	39.4	40.7	62.4	90.3	500.0	168.4	75.4	–
65 or over	308.1	–	100.0	207.4	142.1	444.4	100.0	–	222.2

* Per 1,000 annual exposures

† On an annual basis

more than 50% with advancing age at admission. During the first year they dropped from over 200 to 142. During the second year they dropped from 807 at ages 35 to 39 to less than 500 at ages 65 or over.

Table XIII shows the condition of the patients at the time of discharge. The period of discharge was taken as the first two years after hospitalization because from 85 to 90% of the total discharges occurred during this period. The cohort of 1947–48 could not be included as it had an exposure of only one year.

TABLE XIII

Discharges among first admissions with involutional psychoses to New York civil state hospitals, fiscal years 1943–44 to 1946–47 inclusive, within two years after admission, classified according to conditions at discharge

CONDITION AT DISCHARGE	MALES			FEMALES			TOTAL		
	Number	*Percent of total discharges*	*Percent of total admissions*	*Number*	*Percent of total discharges*	*Percent of total admissions*	*Number*	*Percent of total discharges*	*Percent of total admissions*
Recovered	286	53.3	31.3	685	50.3	28.8	971	51.1	29.4
Much improved	164	30.5	18.0	412	30.2	17.3	576	30.3	17.5
Improved	73	13.6	8.0	219	16.1	9.2	292	15.4	8.9
Unimproved	14	2.6	1.5	47	3.4	2.0	61	3.2	1.9
Total discharges	537	100.0	58.8	1,363	100.0	57.3	1,900	100.0	57.7
Total first admissions	913	–	–	2,379	–	–	3,292	–	–

Of the 3,292 first admissions included in the first four cohorts 971, or 29.4%, were discharged as recovered within two years; 576, or 17.5%, were much improved; 292, or 8.9%, were improved. Thus 1,839, or 55.9%, were discharged with some degree of improvement. There was little variation between the sexes. The percentages of recovery were 31.3 and 28.8 for males and females respectively. For all degrees of improvement the corresponding percentages were 57.3 and 55.3 respectively. For all first admissions the categories of improvement included only 31.2% for males and 34.3% for females. Corresponding data for earlier cohorts are not available. It is highly probable that the current results are superior in view of the known success with convulsive shock therapies.

We may next consider mortality among the cohorts with involutional psychoses. Of the male cohorts an average of 16.2% died within five years. Among females the corresponding percentage was 11.7. The corresponding percentages for all first admissions were 39.0 and 36.0 for males and females respectively. Mortality was heaviest during the first year, 9.5% of the male cohorts dying during this period. Within the first year the greatest mortality occurred during the first three months, a third of all male deaths occurring during this period. Mortality was relatively low during the remainder of the first year and declined to 1.1% during the fifth year.

The trend was similar for females although at a lower level than for males. The heaviest mortality occurred during the first three months of hospitalization and amounted to 5.4% of the total female cohorts. By the end of the first year this had increased to 8.0%. Mortality declined to a minimum of 0.4% during the fifth year. These rates are shown in Table XIV.

Rates of mortality showed similar trends with respect to duration of hospitalization. Among the male cohorts mortality was highest during the first three months, the rate being 229.0 per 1,000 annual exposures. The rate dropped during the remainder of the first year to 48.8 during the fourth quarter and averaged 99.8 for the entire year. It dropped to 45.1 during the second year but rose to 70.2 during the fifth year. Among females the rate was 228.8 per 1,000

TABLE XIV

First admissions with involutional psychoses to New York civil state hospitals dying during specified periods after admission, classified according to percentage and rate

PERIOD OF HOSPITALIZATION	MALES			FEMALES		
	Per-cent	*Cumula-tive percent*	*Rate per 1,000 exposures* *	*Per-cent*	*Cumula-tive percent*	*Rate per 1,000 exposures* *
First three months	5.4	5.4	229.0	5.4	5.4	228.8
Second three months	1.8	7.2	80.8	1.2	6.6	57.5
Third three months	1.3	8.5	63.6	0.7	7.3	33.6
Fourth three months	1.0	9.5	48.8	0.7	8.0	32.7
First year	9.5	9.5	99.8	8.0	8.0	84.4
Second year	2.5	12.0	45.1	1.8	9.8	32.1
Third year	1.8	13.8	66.7	0.7	10.5	25.0
Fourth year	1.3	15.1	64.9	0.8	11.3	31.7
Fifth year	1.1	16.2	70.2	0.4	11.7	20.9

* On an annual basis.

exposures during the first quarter of the first year and averaged 84.4 during the entire year. The rate decreased subsequently to a minimum of 20.9 during the fifth year.

Although more marked among females than among males, rates of mortality in general decreased as the duration of hospitalization increased. Within each period of hospitalization, however, the rates of mortality increased with advancing age at first admission (Table XV). During the first three months, for example, the rate of mortality decreased (probably fortuitously) under age 45 but increased subsequently to more than 600 per 1,000 exposures at age 65 or over. During the first year the rates increased to a maximum of 231.9 at the oldest ages. Rates for females also varied directly with increasing age at first admission. During the first three months they rose, with some fluctuations, to a maximum of 308. During

TABLE XV

*Rates of mortality * among first admissions with involutional psychoses to New York civil state hospitals during specified periods after admission, classified according to age at first admission*

AGE AT FIRST ADMISSION (*years*)	*1st three mos.*†	*2nd three mos.*†	*3rd three mos.*†	*4th three mos.*†	*1st year*	*2nd year*	*3rd year*	*4th year*	*5th year*
					MALES				
Under 35	–	–	–	–	–	–	–	–	–
35–39	1000.0	–	–	–	250.0	–	–	–	–
40–44	189.9	–	–	–	48.2	–	–	–	–
45–49	83.9	67.4	23.3	–	42.1	57.8	–	–	–
50–54	239.8	86.8	59.6	30.5	97.9	28.2	70.6	58.8	–
55–59	149.6	13.3	108.3	70.1	81.3	20.5	39.2	145.4	–
60–64	306.6	169.9	44.9	114.8	147.3	87.9	114.3	–	–
65 or over	709.8	221.7	78.4	–	231.9	115.4	235.3	–	500.0
					FEMALES				
Under 35	–	–	–	–	–	–	–	–	–
35–39	–	–	97.6	–	21.5	–	–	–	–
40–44	153.7	–	23.8	–	43.2	23.4	37.0	–	–
45–49	230.1	37.5	45.3	33.2	83.1	16.9	–	39.0	23.8
50–54	217.2	64.5	16.6	39.3	80.9	33.2	20.8	33.5	–
55–59	308.0	63.2	32.4	41.2	106.2	38.6	44.8	40.4	45.4
60–64	197.6	153.7	80.7	41.8	111.6	57.1	66.7	38.4	–
65 or over	308.1	144.6	–	53.7	121.5	90.9	–	–	888.9

* Per 1,000 annual exposures

† On an annual basis

the first year they increased to a maximum of 121.5 at age 60 or over. During the second year of hospitalization they reached a maximum of 90.9 at age 60 or over.

Discharges and mortality were both relatively low during the first year of hospitalization. As a consequence the percentage in continuous residence remained high during that year. Of the male cohorts 80.9% were still on the books at the end of the first year. Discharges however, increased rapidly during the second year and at the end of that period only 28.6% were still on the books. The rate of discharge declined after the second year and the percentage remaining in continuous residence after five years fell to 13.7.

At the end of each specified period the percentage of females still on the books exceeded the corresponding percentage for males (Table XVI). This resulted primarily from lower death rates among females. At the end of three months 87.6% of the females were still on the books. This decreased to 81.3 at the end of the first year. Because of the high rate of discharge during the second year the percentage still on the books dropped to 32.3 at the end of that period. After five years 18.7% of the female cohorts were still on the books. The median duration was 19.7 months, compared with 19.1 months for males.

SUMMARY

The events in the histories of hospitalization of cohorts of first admissions with involutional psychoses to the New York civil state hospitals may be summarized thus:

Of the male cohorts an average of 68.2% were discharged within five years after hospitalization. Half of the admissions were discharged during the second year with the culmination of convalescent care during that period. Of the female cohorts 69.6% were discharged within five years. As with males almost half of the discharges occurred during the second year. About 80% of those discharged during the second year had been placed in convalescent care during the

TABLE XVI

Percent of first admissions with involutional psychoses to New York civil state hospitals remaining in continuous residence at the end of specified periods after admission

END OF	MALES	FEMALES
Third month	88.4	87.6
Sixth month	84.6	84.9
Ninth month	82.4	82.9
First year	80.9	81.3
Second year	28.6	32.3
Third year	21.0	25.1
Fourth year	18.0	21.4
Fifth year	13.7	18.7

first year. Therefore approximately 50% of the first admissions had left the hospitals within a year, either by direct discharge or placement in convalescent care.

The percentage of discharge from the books exceeded that for all first admissions by 60%. It was on a par with that for the alcoholic psychoses but twice that for general paresis and three times that for the senile and arteriosclerotic groups combined.

Rates of discharge per 1,000 annual exposures were high during the first three months of hospitalization (258.9 for males and 297.0 for females). They rose during the second year to a maximum of 623.9 for males and 585.3 for females. There are no data permitting comparisons with similar cohorts of earlier years. It is highly probable, however, that current rates of discharge must be higher as a result of the use of convulsive shock therapies. For the same reason it is probable that rates of recovery and improvement among first admissions with involutional psychoses exceed those for the years previous to the introduction of such therapies.

Of all male first admissions 39% died within five years. For females the corresponding percentage was 36. Both are greatly in excess of those for the cohorts with involutional psychoses. Among the latter the corresponding percentages were 16.2 for males and 11.7 for females. Mortality was greatest during the first year of hospitalization. Within this period the mortality was heaviest during the first three months. Males had higher death rates than females.

Direct discharges from the hospitals were few during the first year. Mortality was also relatively low. As a result the percentages of patients remaining continuously on the books were reduced by only 20% during the first year. During the second year, however, because of the termination of convalescent care the percentage still on the books was reduced to 28.6 for males and 32.3 for females. At the end of the fifth year the corresponding percentages were 13.7 and 18.7 for males and females respectively. The excess of females resulted primarily from their lesser mortality.

Book Reviews

FREUD ON BROADWAY

By W. David Sievers

New York, Hermitage House, 1955. 479 p.

Freud on Broadway is a happy synthesis of the multiple backgrounds of the author, who has been at various times a professor of speech and drama, editor of *Educational Theatre News,* actor, stage manager, radio and TV writer, in addition to author of studies in psychoanalysis. The result is a book that historically correlates psychoanalysis and the American drama.

It all began as a doctoral dissertation and then fortunately escaped the usual pitfalls of a cold, objective recital or compilation (exemplified by a recent psychological study of the movies). At all times, Dr. Sievers' analytic background reveals itself in his insights into the histories of the writers, their works and their relationships to other writers of the same period in the theater. The analytic interpretations of various plays are necessarily condensed and schematic at times. At other times Dr. Sievers transiently lapses into the more orthodox critic's role.

In general, the book is readable and absorbing, and provides an excellent review of the Broadway theater since Freud emerged from the purely medical into a world movement permeating every intellectual domain.

The book has been enriched by the method of compilation, which involved submitting questionnaires to playwrights concerning their use of analysis, their previous analytic reading and their indebtedness to analysis, if any.

Dr. Sievers reviews the plots and presentations of plays of a large number of major and minor playwrights. His excellent synopses and interpretations repay the reading *per se.* It would be well to point out that the use of Freud in the title is only as an identification of the entire analytic movement; the many references to the works of divergent groups indicate the author's genuine respect for the contributions of Jung, Adler and others. (Eugene O'Neill stated that Jung was the only one of the psychoanalysts who particularly interested him.) The brief introduction to analysis and some of its principal authors is of necessity sketchy but this deficiency is offset by the well-chosen bibliography.

Dr. Sievers ably develops the theme of the change in the American theater from the question of *what* to the question of motivational *why.* He firmly points out that a playwright's chief task still remains to understand and illuminate his fellowman for the audience and that this is now the more possible of realization because of the reunion of dramatist and psychologist after a long separation. He well emphasizes that the essential ingredient in the theater is that the audience achieve a state of awareness implying an intellectual perception of "wholeness" and an emotional release of repressed fears, wishes and anxieties paralleling those of the characters on the stage, be the play tragedy or comedy.

Arthur Miller commented as follows in his questionnaire on the value of Freudian attitudes for the playwright: "Whatever I have received from Freud has come 'through the air.' It is a part of me; I could not, therefore, evaluate it separately. All I can say is that analysts and analyzed people find corroboration in my plays from time to time and so I assume I have been influenced. If so, it is a good influence. I know enough to say, however, that the sche-

matic use of Freud in art is disastrous. The problem of art is not to dramatize Freud, to 'prove' him, but rather to go beyond and discover the total truth of the making of man—the interaction of his inherited nature with the society in which he must struggle to mature—and so to symbolize the disparate as to create 'beauty,' which is the ultimate organization of reality." (The quotation is typical of the cooperation given by the foremost playwrights to Dr. Sievers' questionnaire.)

This perceptive survey is recommended to those interested in the interrelationships of psychology and forms of art and especially to those who have a major interest in the American theater and its development. It offers a bonus in the chance to relive affective theater experiences.—SIDNEY L. TAMARIN, M.D., Brooklyn, N. Y.

THE EARLY YEARS OF CHILDHOOD; EDUCATION THROUGH INSIGHT

By Catherine Stern and Toni S. Gould

New York, Harper & Brothers, 1955. 203 p.

This publication was designed as a help for parents who are caught between the old philosophy and methods of the authoritarian approach and the knowledge of modern child psychology and psychiatry. Instead of the two extremes—the former's use of power and the helplessness of many of today's parents in trying to apply the newer concepts—the authors intend to show a middle road. They call this third way education through insight. It means that parents, knowing and understanding their children, may produce or rearrange situations and experiences which lead to a desirable change in their children's behavior.

The authors speak out for careful planning by the parents of an "indirect approach" which replaces personal interference by the parents and their feelings with a more impersonal objective situation. They cite many instances, writing clearly and easily for the reader to understand. The fact that all examples are taken from long experience in their own families or in nursery school may convince the reader of the correctness of these ideas. There is no doubt that the book will be read by many parents with great relief.

It leaves the reviewer, however, with a feeling of disappointment and frustration. The authors quote (critically, I thought) some of the questions of anxious parents who have tried to follow and apply modern psychology—questions such as: "We followed the book. Where did we make mistakes? Whose fault is it?" (p. xii) The danger is that the same will be done with this book. It does not help parents to face the problem efficiently, to think, to find a solution through real understanding of the individual situation (which is far from any *laissez-faire* attitude). The examples describe concrete situations, *e.g.*, "the poor sleeper," "the poor eater," etc., which all show happy endings and so might encourage parents to take them as prescriptions. It would have been worthwhile to show the differences between the published cases and those where expert help is indicated.

However, the authors give a very good and colorful picture of the confusion many parents are in today, but very little space is given to explaining it, the necessity of its temporary existence, and the hope for its solution. When we consider the results of fifty years of research, observation and practical experience in psychology and psychiatry, we understand that they mean a profound change in our approaches and attitudes toward children. We also know that such change cannot be effected without the pain of insecurity and anxiety which is

connected with our own growth and development. If we have the courage to face a difficult interval we may not need to avoid the "direct approach" for the "indirect" one the authors recommend because our children should know us as human beings with the right to our own feelings.—LOTTE BERNSTEIN, M.D., University of Louisville School of Medicine

MINISTRY AND MEDICINE IN HUMAN RELATIONS

Edited by Iago Galdston, M.D.

New York, International Universities Press, 1955. 173 p.

The significant discoveries in the fields of medicine, the growth in the social sciences and the new interest in man have also affected the worlds of religion. These advancements can but influence the religious teacher who is interested in the well-being of the human personality and in the salvation of the human soul. Moreover the psychologists and the new "physician of the soul"—as Erich Fromm has termed the psychiatrist—are making it clear that the growth of the individual and the maturation of the human personality are closely linked to the religious and spiritual resources of the church and the synagogue.

The present-day trend that encourages Americans to go to their places of religious worship is based upon the recognition of the role that religion can play in fostering family stability and creating for the individual what the Overstreets have penned as "emotional resiliency." On the other hand, no religious teacher will deny the important position held by the physician, the psychiatrist and the therapist in bringing help to the body, mind and spirit of men. Yet more often than not these two worlds of ministry and medicine, basically concerned with man and his well-being, have been at odds and even antagonistic to each other.

Dr. Iago Galdston in his thoughtfully constructed *Ministry and Medicine in Human Relations* graphically illustrates this point in his introduction to this series of conference papers and learned essays. He writes, "Whatever were the vagaries in the relationships between church and science in the long span of history, it is most certain that at all times man had need for the ministrations of the physician and of the minister. When these functions were not and could not be effected within and by one and the same person they were shared by two persons—both termed doctors and both exercising a therapeutic relation to the individual whom they served. At first the sharing was close and harmonious. However, with time and the growth of science, the two grew apart, so that today they are remote one from the other, strangers to each other with little understanding of the other and at times with even less of sympathy."

This new edition of the creative work of the men and women of the New York Academy of Medicine illustrates the insight that both physician and theologian have gained in recent times as to the relatedness of their respective fields and the support they can give to each other in helping others to help themselves. As editor of the proceedings of two conferences sponsored by the New York Academy of Medicine Dr. Galdston brings to the public the excellent and provocative essays of men of medicine and men of religion. The papers and essays of Otis R. Rice, Erich Lindemann and Sandor Rado of the first conference deal with the common areas of the physician and the minister. The essays discuss the many ways in which physicians and ministers can cooperate in serving people and how each profession can help the other carry out its

particular purpose. The papers of the second conference, an outgrowth of the first, deal with basic moral questions that the world of psychiatry and the field of psychotherapy have yet to treat and explore thoroughly. It is not the purpose of the reviewer to analyze or report on the thoughtful essays of the sociologists M. F. Ashley Montagu, and August B. Hollingshead, of the religious philosopher Paul Tillich or of the physicians and psychiatrists Leo Alexander, Gregory Zilboorg and Robert A. Clark—except to say that all these papers should be a reading "must" for both ministers and physicians. Both professions will recognize in this work the common roles that both have "to play in facilitating human relationships" and they will discover as well that both struggle and grapple with the same moral and ethical problems of life and human existence.

In the fields of medicine, psychiatry and dynamic psychology scientists and technicians have gained insights, developed skills and perfected techniques for helping individuals. These means are used to help individuals to adjust and live more adequately in their environment, thereby bringing them constructive and satisfying experiences in all their relationships. But helping people to live with others implies moral judgments and ethical standards that have not as yet been clearly and openly defined by these new human relationists. On the other hand, religion has forged from the crucible of centuries of human experience a philosophy that has formulated value judgments and has accepted ethical principles and verities. Through a fusion of these understandings, goals and techniques of modern medicine and these value judgments and truths of religion (in our case the Judeo-Christian tradition) ministers and physicians can forge a new dynamic synthesis for understanding and helping human beings to life abundant and to salvation.

The work of these two conferences as illustrated in *Ministry and Medicine in Human Relations* is an excellent beginning. Moreover appreciative acknowledgment should be given to the men and women who planned and worked at these conferences and also a word of gratitude to Dr. Galdston for bringing these basic concerns in human relations to a wide reading public and to the ever-growing professional class of human relationists.—DR. JESHAIA SCHNITZER, Montclair, N. J.

THE TEACHER AND THE CHILD: PERSONAL INTERACTION IN THE CLASSROOM

By Clark E. Moustakas

New York, McGraw-Hill Book Co., 1956. 265 p.

The basic point of view of this book is that personal growth occurs in human interaction. As the author states, "The aim of the teacher is to recognize and appreciate the unique perception of the individual child as expressed in the personal relationship. In such a setting the expression of uniqueness and individuality is encouraged."

The book reports on personal interactions in the classroom as selected from materials gathered over a period of a year by 92 elementary and secondary teachers from four school systems. The teachers met weekly in small groups for approximately three hours to discuss their programs. Each teacher planned individually or from suggestions by the group a special approach to or an experiment on personal interaction in her own classroom. A record of these classroom experiments was kept by each teacher in the form of careful notes or by tape recordings.

The eight chapters of the book are "The Basis for a Personal Relationship between the Teacher and the Child," "How Children's Emotions Develop and Grow," "The Individual Child and His Emotions in the Classroom," "Sensitive Listening to Emotional Expressions of Kindergarten Children," "Experimental Mental Hygiene Approaches in the Early Elementary Grades," "Interpersonal Relationships in the Later Elementary Grades," "Self-Exploration among High School Students" and "Successes and Failures in Creating the Interpersonal Relationship in the Classroom."

Throughout the book (and from kindergarten through high school), the teacher's approach is to accept, understand, emphasize and listen and not to evaluate, probe, diagnose, interpret or even "teach." The sustained adherence to this point of view and in fact the repetition of these basic principles in the efforts of the several teachers carries conviction and brings belief to the reader. This reviewer is impressed by two of the book's observations: To accept a school child and to listen to him is difficult, and to accept a school child and to listen to him is the most important task of the teacher. This book does not tell how to become a sensitive listener; rather it leads the reader to want to discover for himself new approaches to human interaction in the schoolroom and elsewhere.

To read of the episodes in the life of a seriously disturbed 1st-grade child in a class of 40 children and of how these classroom disturbances were handled by the teacher should give courage to anyone (pp. 143–51). This teacher seemed to be able to differentiate between liking a child and not liking his behavior, and was successful in communicating this to the child in question.

The book ends with a chapter on successes and failures. It reports, "Not all the teachers who attempted to work out special relationships with individual children were successful. Some were uncertain about the results and others indicated definite failure. Of the 92 teachers who attempted the special relationships, 67 evaluated them as worth-while experiences, 9 classed them as failures and 16 were uncertain."

In reading this book one senses an honesty of purpose and an integrity in reporting the successes and shortcomings of the many experiments in the classroom. The author himself restricts his discussion to a small fraction of the book. In the first two chapters he gives only a bare outline of basic principles of human interaction and personality growth. Some readers will no doubt want much more didactic material and more discussion of the theory and principles of individual psychology and mental hygiene. Others will want to see such experiments by teachers subjected to scientific procedure with quantifiable measures of the changes in the teachers and in their children.

In any case this is a book to be read, discussed and used as a starting-point for further experimentation in human relations in the classroom.—GLADYS L. ANDERSON, Michigan State University

PROGRESS IN CLINICAL PSYCHOLOGY

Edited by D. Brower and L. D. Abt

New York, Grune & Stratton, 1956. Vol. 2. 364 p.

Periodic reviews of theories and practices in clinical psychology are desirable on several counts: They give integrated reports of the activities of psychologists. They bring together leading specialists who present comprehensive and illuminating summaries of work done. They define changes in practices and research procedures, permitting an estimate as to which of them constitute

progress and which merely reflect differences in emphasis. They provide a broad perspective for scientists interested in structuring scattered knowledge into unified and generally applicable theories.

The volume edited by Brower and Abt satisfies these points most adequately. The 22 chapters, each written by a different contributor, are divided into five sections: I. Introduction. II. Assessment and appraisal processes. III. Psychotherapeutic and counseling processes. IV. Special applications of clinical psychology. V. Approaches to clinical psychology.

Abt's thoughtful introduction deals with changing viewpoints through the history of psychology. He himself favors a transactional theory of mental adjustments over the actional and interactional theories. Differences between these viewpoints, points, though not particularly striking, are well elaborated and documented by quotations from philosophical writings.

The assessment part is limited to the projective tests: Rorschach, thematic apperception, sentence completion and human figure drawings. Intelligence tests, aptitude tests and personality inventories are not covered in this edition.

The 12 chapters on therapy and counseling include detailed discussions of a variety of methods: psychoanalysis, client-centered therapy, group therapy, remedial reading, speech treatment, the media of music, art, books, drama, dreams, and hypnosis in therapy.

The fourth section deals with the role of psychology in the diagnosis and treatment of social offenders, psychiatric patients and the physically disabled. Neuropathology of the visual cortex, statistics and research in therapy are taken up in the concluding part of the volume.

All topics have been assigned to seasoned specialists and capable authors. Their reviews cover varying periods of time, from the last three to ten years. They presuppose better than average familiarity with the subject matter. The organization of contents varies with the writer and his domain. The chapters contain a wealth of information and numerous references for further reading.

The presentations by J. Seeman on client-centered therapy, B. R. Bach on group therapy, G. W. Gens on speech disorders, L. S. Kogan on statistics and I. N. Mensh on research in therapy seem especially effective.

The book is typified by emphasis on moderation and a sober regard for definitions of concepts, processes and results. Perhaps the era of hosanna-shouting in clinical psychology is over. The need for a comprehensive and unified personality theory is recognized by those writing on projective tests. Piotrowski's view that the formal structural aspects of the Rorschach may be more fertile as personality measures than content analysis is well taken. The search of Wyatt and Veroff for consistent relationships between fantasy (as applied to TAT) and manifest behavior is relevant. It is to be hoped that a systematic exploration of fantasy will include the fantasy life of psychologists, who may in this respect be deviant from the people they study. The tendency to jam reality into borrowed theoretical molds of unknown validity is still all too prevalent. For example, the claims of depth analysis seem shopworn and shallow. Symptoms with temporal priority are unquestioningly mistaken for deep causal genotypes.

In the area of therapy the potential usefulness of each technique is clarified by a balanced discussion of its assets and liabilities. The various approaches give psychologists considerable opportunity to project their own predilections. The danger is

that therapists will become narrow technicians inexperienced in the art of choice of the right method for the right person at the right time. The broad-minded therapist has of course a chance to learn of new ways of treatment which may improve his therapeutic relationships.

The aims of therapy, it appears from the materials presented, are attitudinal changes, improvement of subjective feeling states and modification of reality contacts. The restructuring of basic personality is rarely mentioned as a true objective of therapy. Most therapeutic hypotheses overlook the multidimensional nature of emotional and social conflicts and maladjustments. Here again the contents of behavior (symptoms) are given much more attention than the underlying forms of personality expression.

The three papers on applications of psychology carefully analyze the administrative, professional and research problems which remain to be solved if psychological services in jails, clinics, hospitals and state institutions are to be maximally useful.

The chapters on research bring into focus the numerous and complex dilemmas inherent in the objective study of mental abilities, adjustments, therapeutic procedures and results. They inspire a sense of humility and restrained confidence.

The age-old and troublesome question of localization *vs.* integration of the function of the nervous system is still in the forefront. Kogan emphasizes the point that clinical statistics are only as good as the insights of creative scientists; population samplings, ability and test samples, examination procedures, choice of measuring instruments and interpretations are all sources of bias in reporting clinical results.

Research in therapy includes the study of therapist, clients, procedures and outcomes in relation to intended objectives. It demands rigorous criteria at each stage of investigation. It has major selective and coordinating functions, favoring purposeful eclecticism. The neutral reader carries away the impression that research in projective tests and therapy would be more helpful if designed and carried out by persons not directly involved in diagnosis and treatment. Test of significance might then go beyond the confirmation of personal preferences.

Progress in Clinical Psychology is a most stimulating and informative volume for all who practice and do research. It is bound to broaden the reader's horizons and challenge his capacity for constructive thought. —Joseph F. Jastak, Ph.D., University of Delaware

SIGMUND FREUD: FOUR CENTENARY ADDRESSES

By Ernest Jones, M.D.

New York, Basic Books, 1956. 150 p.

These addresses by Ernest Jones on the hundredth anniversary of the birth of Sigmund Freud are a fitting tribute to a man whose long and arduous years of scientific investigation, discoveries and insights contributed so richly to the knowledge of mankind. With understanding, humility and dignity the author of these essays calls to remembrance the greatness of Sigmund Freud, who gave meaning, purpose and direction to human behavior, who explored and mastered the forces of the unconscious, who established a scientific method for the investigation of human behavior and who founded a theoretical and technical body of knowledge which has had a profound effect on man's attempt to understand himself and the social institutions created by him.

The volume consists of four addresses ("The Nature of Genius," "Our Attitude

towards Greatness," "Psychiatry before and after Freud," and "Sigmund Freud: The Man and His Achievements") and a eulogy ("Sigmund Freud, 1856–1939"). Although the addresses rightfully deal with the subject from a personal standpoint because of the author's relationship to Freud, they have historical significance for they put into perspective the world-wide influence of Freud's accomplishments. This is achieved with the avoidance of adoration and idolatry. The first two addresses are a tribute to the founder of psychonalysis for they are fascinating psychoanalytic studies of the essential characteristics of a person considered to be a genius and of our attitude toward such a person. The concluding essays concretize this theme by setting forth the broad influence of Freud's contributions to the development of psychiatry and by dealing with Freud both as a living personality and as one whose achievements have had a profound effect upon man's knowledge of a great variety of psychological and social problems.

"The Nature of Genius" could have been titled "Some of the Factors Conditioning the Workings of Certain Forms of Creative Thinking." It is a scientific investigation of the creative process with the theme centered around Freud and his works. The psychological characteristics of the creative process are considered in their relation to scientific production rather than artistic inspiration and this determines the outcome of the psychoanalytic study. The popular concept of genius is put aside in order to investigate the regular laws of mental development and functioning. The impact on the observer of the products of the creative mind evokes a feeling of surprise because of its seeming intuitive inspiration. The result observed appears to be spontaneous for it is fused with the element of mastery, the act of apprehending the inner nature of things. Therefore the creative person is looked upon by the observer as a child looks upon the father whose wisdom has expanded the child's horizon.

Considering the many who are born with innate talents, what is it that determines the relative value of man's contribution to his fellow men? It is exemplified by that which Freud himself demonstrated in relation to the laws of mental activity—that is, its inherent service, its utility, the use to which it may be put. Freud's achievements were not based on height of fame or popularity. They were based on the creation of a scientific method which has demonstrated its utility. His contributions were the outgrowth of the courageous investigation of human nature in the crucible of scientific humanitarianism although he was faced with the most intense popular prejudices. And so acceptance was slow due to the very nature of the phenomena investigated. Certain characteristic attributes of the creative mind appear to be necessary. These are absolute honesty and love of the truth which allows for an entirely fresh way of looking at things, a sense of the really significant which permits the generalization of a finding, and the power of intense concentration where there is some special coincidence between the unconscious impulses and some essential feature of the objective problem. The necessary attainment of a peculiar degree of harmony of the elements making up the mental apparatus is investigated and the analytic basis for this is set forth in detail.

"Our Attitudes towards Greatness" is a comparative study of the achievements of Freud in contrast to those of other great men of science such as Newton, Copernicus and Darwin. For us who evaluate the greatness of a man there may be the tendency to follow our own bias, be it adulation, a critical attitude or a frank assault. The

author gives us the opportunity to chuckle at ourselves as he expounds the psychoanalytic implications of our reactions. We are cautioned that it would be the better if we are guided by a sure compass—that is, honesty and integrity—as we explore the qualities in a man's personality that constitutes greatness.

The third address, "Psychiatry before and after Freud," is a historical review of the changes ascribed to Freud over the last sixty years. His scientific interest was aroused by a burning curiosity and by a sincere and devoted endeavor to understand and treat the mentally ill. There was a continuous attempt to systematically classify mental illness in terms of psychological concepts. His methods of investigation and his observations resulted in a medical psychology which emancipated itself from prevailing neurological theory. Freud's study of the neurosis and the more familiar normal introduced a humanistic attitude into psychiatry which was not always present previously. His contributions to the study of schizophrenia and melancholia contributed to the psychodynamic investigation of these disorders without ignoring the implications of organic chemistry. More than that, they gave enlightened understanding to what was a morass of horror and despair. Although his achievements were not the only force, indeed they were and are a major influence in advancing the assault on mental illness and in contributing greatly to the development of the mental hygiene movement. There is a review of the broad impact of his work in widening the scope of psychiatry, medical education, the general practice of medicine, child guidance and education, marriage and family life and the neighboring fields of science.

The last address concerning "Sigmund Freud: The Man and His Achievements" presents psychoanalysis as a new concept of the mind, the foundation of a new department of science which constitutes a revolutionary approach to the broad understanding of psychological and social problems. Some of the unique characteristics of Freud's personality which motivated his achievements are recorded and, so to speak, give life to the personality of Freud, the type of man he was.

The eulogy is dedicated to Freud, the man, the physician, the scientist, the humanist who possessed and shared with others personally and through his writings a deep understanding of the laws which determine human behavior. He profoundly and abundantly contributed to the knowledge of human nature and charted an interminable path for others with scientific curiosity to explore and expand upon.

This inspiring volume will have a different meaning for men of different interests. It is a marker recording the past and pointing the path to the unknown future. It is written with an ease of style and its vitality and intimacy of communication are refreshing. It should be a welcome addition to any library of psychoanalytic literature and the literature of the allied sciences.—SIDNEY BERMAN, M.D., Washington, D.C.

AN OUTLINE OF SOCIAL PSYCHOLOGY

By Muzafer Sherif and Carolyn W. Sherif

New York, Harper & Brothers, 1956. 792 p.

Much in social psychology is shadowy, much is elusive, much is hard to bring before the bar of science, but little finally eludes the Sherifs.

In this "major revision" (as the publishers call it) of what was already on first publication a major work we have something more than that: There is revision, there is sub-

stantial expansion in time to sweep in the work of the last decade, there is expansion in topic to put groups in the context of other groups and of the wider society, there is more attention to crisis as having historic bearing and there is expansion of the authors' well-known theory of ego-involvement.

The result is an *interesting* book and that is no mean compliment when the student's or professional's interest needs sustention over 770 pages exclusive of index. What sustains the interest is the well-judged amount of concrete material used in illustration; the authors neither cluttered the text with "everything" nor left it thinly abstract. Much of the illustrative material is reported with unusual vividness because it refers to the work of one or the other or both of the authors, together, alone or with others. (There are no fewer than 80 unduplicated references in the book to the authors' previous publications.)

Also sustaining interest—with almost a detective-story quality—is the range of the authors' knowledge over the anthropological-sociological and the psychological-psychiatric literature and the ingenuity of their attempts to weave consistent theory and to test it experimentally. Both the latter efforts deserve respect even though they are less than wholly successful as, in the present state of knowledge at least, they undoubtedly must be.

The basic position of the authors is that a social psychology which accounts for experience and behavior in terms of external factors is as one-sided and limping as a social psychology that makes its account in terms of internal factors. External and internal refer to the individual (or at points to "the organism") and the skin is quite frankly the boundary-line for the distinction. (The subtle difficulty of this kind of physical-spatial localization for psychological phenomena does not bother them at all nor, it must be admitted, does it get in the way of practical analysis.) They state, "Behavior follows the central organization or patterning of all these factors [external stimuli and internal impulses]." but (in their next sentence say that) "psychological structuring is jointly determined by external factors" (p. 79). If the authors meant (as they well might) that the "internal and external factors" and the "patterning" or "structuring" of these (as far as is relevant for social psychology) are mutually determinative, the view would be well worth stating clearly. As it is, we appear to have two views in unresolved contradiction.

Indeed it is here at the conceptual level on which the book prides itself most that, in this reviewer's judgment, the greatest weaknesses occur. Definitions of single key terms are variously vague or untenable in the context or different from the authors' intent and usage. For instance, they quote with approval Herskovits' definition of "culture" ("Culture is the man-made part of the environment"); thus with reference to, say, radio-activity the part that originates in the cosmos is presumably "nature" and the increment resulting from atom-bombs is culture (the man-made part of the environment). It is obvious that the authors do not so intend, but this is what they seem to say. And as with this term so it is for many if not most of the key terms and for the theoretical structure built out of the no less vague or imprecise linkages between them. This is not so much a defect in the psychology as in the logic. The authors give a convincing impression of really knowing how people *do* act; it is only when they try to conceptualize and build theory that one feels they could have benefited from the aid of lexicographer, logician and semanticist.

The book cannot be adequately described

in a review. It is beautifully printed, well and generously illustrated, finely indexed; it is well-organized topically and compendious in its range. It is well worth anyone's reading. Only on the side of its claim to a clear, consistent theory is it more challenge than achievement.—JOHN R. SEELEY, Community Surveys, Inc., Indianapolis

SPECIAL EDUCATION FOR THE EXCEPTIONAL

Mental and Emotional Deviates and Special Problems

Edited by Merle E. Frampton and Elena D. Gall

Boston, Porter Sargent, 1956. Vol. 3. 699 p.

This is the third and last volume of a survey of exceptional individuals. It includes descriptions of their general characteristics and of the special educational methods, vocational guidance and placement programs suited to their needs. Although written chiefly for the use of educators, this should also be a valuable reference volume for psychologists and social workers in clinical and other settings which bring them into contact with the exceptional and their problems. The book is too long for detailed reviewing but it may be possible to suggest something of its scope even in a brief review.

The papers collected here are grouped into 11 sections. The six papers in the first section outline the special characteristics of gifted children and suggest what kind of education should be provided for them. Emphasis is placed upon early identification of the intellectually superior in order to institute appropriate educational measures as soon as possible. Although stress is placed upon the gifted individual's potentiality for intellectual and social leadership it is recognized that not every such person will become a leader. As one of the authors states, personality, attitudes and drives are quite as important as intelligence in the development of leadership.

Following these papers on gifted children are three on children with brain injuries, nine on cerebral palsied children, four on the hemiplegic and six on epileptics. Quoting Phyllis Greenacre, Dr. Lauretta Bender describes the predisposition to anxiety of brain-damaged children and concludes that they are brighter than often assumed and that their seeming mental retardation is more frequently the result of their anxiety, isolation and disorganization than of true mental deficiency. On the other hand, the contributions on cerebral palsied children indicate that about 50% of them are mentally defective (with IQ below 70) and that speech defects occur in about 75%. Thus these children tend to be handicapped educationally by their intellectual limitations far more than by their physical condition. Recent studies of epileptics, however, are more encouraging than those of the cerebral palsied. Epileptics are no longer considered subject to "mental deterioration" and according to statistical studies based on mental test results their intellectual abilities conform closely to those of any unselected group in the general population. The old concept of an epileptic personality has been superseded by the explanation of personality difficulties—found in cases with idiopathic epilepsy—as psychological reactions to uncontrolled seizures or to the attitudes of family, school and community toward the disease.

There are 11 papers in the section on emotionally disturbed children; four of these are on juvenile delinquency. Psychologists and social workers in psychiatric clinics for children may find the statistical data reported in these papers of interest but

the material presented will for the most part already be familiar. The nine papers on mentally retarded children are also likely to be of more value to educators than to clinical workers.

The last seven papers are concerned with problems of the aged, alcoholism and drug addiction in general.

Altogether, 69 authors are represented by the papers in the book. Their contributions are supplemented by bibliographies on each topic—that is, there is a bibliography on the intellectually gifted, one on the brain-injured, one on the cerebral palsied, and so on. The books and articles listed have been classified under such headings as general references, educational references, medical references, psychological references, social work references, etc. This should be very helpful when anyone wishes to do further reading on some particular aspect of a topic. The editors are to be commended not only for their general planning of the volume but specifically for the excellent bibliographical arrangement.—PHYLLIS BLANCHARD, PH.D.—*Child Guidance Clinic of Delaware County, Pa.*

NEW LIVES FOR OLD

By Margaret Mead

New York, William Morrow & Co., 1956. 548 p.

Margaret Mead's newest major book has important implications for social psychiatrists and other students of behavior interested in new perspectives on American culture, medical researchers interested in relationships between stress and disease, theorists of social change and the administrator and man of affairs involved with various forms of culture-contact: technical assistance, religious missions or the relationships between overseas businessmen and "native" personnel. Furthermore educators and social philosophers can find in the book new ideas about pertinent 20th-century goals for educational planning and about the unity of the socialization process so that formal school systems can be seen as but one part of the total complex of influences on character and personality formation.

This is a big order. But Dr. Mead has filled the 18 chapters of the book (and rich appendixes) with enough for people in the above and other categories to ponder and do further research about for a number of years.

The title refers to the "new lives" of the Manus people of New Guinea. How they transformed themselves rapidly from the Stone Age way of life they practiced when Dr. Mead first visited them 25 years earlier to participate in the Atomic Age of 1953 is the *leitmotif* of the book. Individual characters in this drama of social change, such as Kilipak and Paliau, "the man who met the hour," emerge in the book through both photography and description. Thus the reader is able to fasten Dr. Mead's widest generalizations (about the possible direction of world societies) to *observed* particular personalities.

It is an intensely warm and personal book. At the same time it is a scientific treatise by a scientist who is constantly aware of the necessity of identifying the observer and the observer's actions as they affect the observed. Dr. Mead gives us an anatomy and critical history of her own ideas, and tells how with the help of her field assistants, Ted and Lenore Schwartz, plus a battery of Gesells, Bender-Gestalts, Mosaics, and photographic memory tests, she served as a medical therapist, banker, teacher and storekeeper in doing her field work.

Apart from its scientific and practical interest, *New Lives for Old,* written with

the imagery and colorful detail which marked her early classics, also has literary appeal for the layman. (For example, in describing the village where she lived for six months the author writes: "The church itself, because it was built on the ground while all the other houses were on posts and because it was so much bigger, seemed like a huge mother hen, brooding over a set of identical little brown chicks.")

What are some of the frontiers of behavioral research that Dr. Mead opens up? One is in her discussion of the possible unity of psychological mechanisms related to social change, religious conversion, extremist political commitments and psychotherapy. In a provocative appendix on implications for mental health and education, she hypothesizes: "Only by the destruction of every vestige of the past can the new order be ushered in. It seems likely that this will turn out to be one of the universal characteristics of human psychology" (p. 523). The Manus people illustrate this point. They repudiated the past symbolically by throwing their possessions into the sea and in one generation created new institutions: the two-generation family, freedom of women, political democracy, sense of community, ideals of human dignity and stature, a psychosomatic theory of disease and a capacity to deal with boundaries in space and time (p. 363).

In showing how the Manus in a sense "turned themselves wrongside out" under the stimuli of the American army in World War II and yet emerged with a working society, Dr. Mead asks that mental health workers study the Manus' experience to understand better the importance of group support when dealing with people who have experienced transformation. Totally new patterns, where basic human relationships are not broken by incongruous mixing of old and new (p. 452), may provide the cushions for individuals who otherwise might find intolerable working out a new way of life alone. This applies as much to the Manus as to the alcoholic, the reformed convict, the patient with shock therapy or lobotomy or the "urban secularized people of the modern world" (p. 525).

On the other hand, Dr. Mead asks that group support not become so protective and self-sealing that individuals become cultish, defensive and thus prevented from participating in other societies or sub-groups that make up modern society. These remarks should be read in the light of the Eaton and Weil studies of the Hutterites, *Culture and Mental Disorders* (reviewed in MENTAL HYGIENE, July 1956); various recent studies on the *kibbutz* in Israel; and the findings in 1952 of the Chichester seminar of the World Federation of Mental Health, outlined in Soddy's *Mental Health and Infant Development.*

Students of American child-rearing practices will find Chapter 13, "Rage, Rhythm and Autonomy," of special importance. Such comparative materials help bring us to wider "definitions" of what constitutes mental health, *i.e.,* how original elements of "guilt," "anger," "sin," "tension," "puritan personality" and "reciprocity" can be woven into an adult personality which fits modern institutions. Manus children, like American children, are given early training for independence but are not subjected to the sanction of "conditional love," which Dr. Mead in her earlier *Male and Female* described as a characteristic of certain American parents' ways of getting the young "to behave."

Similarly, psychotherapists and religionists interested in the psychology of grief will find interest in how the Manus deal with death as part of the new way: "The swift furious display of completely abandoned sorrow is felt as safe and cathartic. But pro-

longed grief corrupts the minds, leads to depressions and self-destruction. . . ." (p. 273). Practitioners of group psychotherapy, on the other hand, will find relevance in the Manus' shifts between preferences for auricular confession (Roman Catholic) and public recounting of sin (p. 325).

With such a stimulus as the Manus' experience provides for a fresh examination of our own problems, we can be grateful to this new example of our "primitive heritage," our eternal debt to faraway people whose choice to enter the modern world gives dramatic testimony to the maleability of human beings. We need this restoration of wonder.

For such wonder is helpful at this juncture when, as Dr. Mead writes, "we have to rear people who can tolerate the unknown, who will not need the support of completely worked out systems, whether they be traditional ones from the past or blueprints of the future."—WILTON S. DILLON, Society for Applied Anthropology

PSYCHOLOGY: GENERAL, INDUSTRIAL, SOCIAL

By John Munro Fraser

New York, Philosophical Library, 1956. 310 p.

The purpose of this book, according to the author, is to meet a need expressed by the Committee on Education for Management. The aim is "to give students some training in the art and science of handling men." John Munro Fraser has attempted to survey the fields of general, industrial and social psychology "from the manager's point of view and to draw the main issues together within reasonable space." A noble purpose indeed!

This book suffers, as do others that try to be omnipresent, from inadequate treatment of any one subject. The "manager" is likely to be left with the dangerous "little knowledge." It seems justified to take to task the author who deludes himself into thinking he can adequately explain, in a satisfactorily comprehensive way, subjects ranging from classical thought and scientific method to the social anatomy of an industrial company—all in 300 pages.

To have achieved the intended purpose better, the field of clinical psychology in industry might well have been presented rather than history and other subjects. Other authors, notably H. Clay Smith, have achieved the goal far better. The sad omission of recent research findings in many areas makes this a rather old book although published in 1956.

The attempt to combine general psychology, social psychology and industrial psychology is a noble one, but the results do not justify the efforts. Each is a broad, intensive area in itself. Of necessity, each receives only cursory treatment. Each section gives the impression of a rather rough *précis* of other texts in these areas. To accomplish the intended purpose, a book with the theme of clinical psychology in industry would much better have served the purpose.

Of what real value is it for the manager to be familiar with the physiology of the ear if he is being trained in the "art and science of handling men?" What happens to the manager's motivation when he finds himself plowing through learning curves and deductive reasoning steps?

While the author devotes a page to Gestalt psychology, he does not succeed, in this writer's opinion, in creating a *gestalt* out of a 3-part text. The average reader in industry is likely to fail to come away from his reading of this book with a useful, applicable body or entity of knowledge. Rather, the probable result will be a gathering of more or less interesting facts con-

cerning behavior. Although the flyleaf claims success, there is missing a central theme, an underlying motif that would enable the lay reader to get the feel of the purposiveness of behavior, its goal orientation, the logic and understanding of dynamisms—in short, the types of information in readable form that could be used to real advantage in on-the-job situations.—MARTIN M. BRUCE, Dunlap and Associates, Stamford, Conn.

MENTAL HYGIENE: A SURVEY OF PERSONALITY DISORDERS AND MENTAL HEALTH

By D. B. Klein

New York, Henry Holt & Co., 1956. 654 p.

D. B. Klein has approached his subject from an educator's point of view. He has presented a general textbook which would be most valuable in undergraduate courses and would also have value for medical and nursing students. The various schools of thought in psychiatry are discussed and a wide range of literature is reviewed and summarized. There is an uncomplicated but adequate glossary. This is not a short book but both print and style make it easy to read.

The author has presented an excellent introduction and historical summary of mental hygiene in Part I. This section would merit a separate printing as a clear and succinct discussion of the subject and field.

In Part II, The Nature of Mental Disorders, and Part III, Preventing Mental Disorder, the discussion is based upon the 1934 nomenclature and therefore dates the book regrettably. In Chapter 5 the conclusion that it is better strategy to concentrate on preventing schizophrenia than on preventing traumatic psychoses because of the larger numbers of patients with the former diagnosis will seem false to most clinical workers. The assumption concerning the low incidence of psychoses in children under 15 is based upon admissions to state hospitals—a most unreliable statistical base.

In the chapters on prevention of mental disorder there are several excellent discussions. The falsity of many of the statements concerning the increase in mental illness is logically proved. The author spends considerable time pointing up the responsibility of the mental hygienist in the prevention of all types of mental disorder by physical and social means as well as psychological. It is a pleasure to read that experts can disagree on points and still be worthy of respect (p. 201)! There is an excellent defense of teachers, with exposure of the unreal and unfair standards against which they have often been judged.

At times it seems the author is advocating education, individual and collective, as the prophylaxis against all mental disorder, but he also points out the danger of accepting any hypothesis as a fact and stresses that other approaches are possible and valuable.

Part IV, Promoting Mental Health, is a comprehensive and balanced review of both theoretical and practical approaches. There is a philosophical tone to many of these chapters that barely escapes being hortatory. Nevertheless this section offers a number of constructive suggestions that teachers and others interested in promoting mental health would find valuable. The warning against confusing cause and motivation and the discussion of perfectionism as a mental hygiene evil are two examples.

This book is a sane, comprehensive review of the field of mental hygiene and of the responsibilities of those interested in mental health. The discussion of mental

illness leaves much to be desired. Otherwise it can be highly recommended as an introduction to the field of mental hygiene and mental health.—MABEL ROSS, M.D., U. S. Public Health Service

THE PSYCHOANALYTIC STUDY OF THE CHILD

By Ruth S. Eissler, Anna Freud, Heinz Hartmann and others

New York, International Universities Press, 1955. Vol. 10. 394 p.

The present volume of this well-known series of annual publications continues in its established tradition of excellence and fulfills all reasonable expectations. It contains 19 contributions, all of them competent and of top standard. The articles treat important fields of child psychology and development; some concern theory, others provide clinical and casuistic material.

It is difficult, without going too much into detail, to review all this valuable material. All the topics are of equal importance, often highlighting difficult and very intricate problems, as for instance Greenacre's and Mittelmann's material on fetishism. Hartmann and Kris deal with the theoretical aspects of sublimation and neutralization.

There is perhaps special reason to call attention to a most significant contribution from Max Schur: "Comments on the Metapsychology of Somatization." This is a paper of more general theoretical interest. Presenting an analysis of a patient with a neurodermatosis, Schur deals with dynamisms of the highest importance for the understanding of psychosomatic disorders. At the same time he illustrates etiological problems as problems of treatment.

Despite their difficult aspects, all the papers are equally important. They deliver a colorful and penetrating survey of the high level of modern psychoanalytic research in a very impressive and convincing way, and very little in them may arouse criticism.

The volume stands as indispensable reference material for any psychiatric library.—PAUL J. REITER, M.D., Copenhagen

FOUNDATIONS OF HUMAN BEHAVIOR: DYNAMIC PSYCHOLOGY IN NURSING

By Theresa G. Muller

New York, G. P. Putnam's Sons, 1956. 254 p.

This work is presented as "a guide in select- and communicating appropriate content" which can serve as a basic orientation for nurses. The contents include an introductory section, in which the development of psychology, goals of nursing, and personality are discussed. Then a section on the "driving forces of human nature" is followed by two sections on the dynamics of human behavior.

The author draws heavily upon her previous publications as well as on a wide selection of the literature on human behavior. Several recorded discussions which are included give the reader an opportunity to reach conclusions and compare them with those given in the text. Many areas of behavior pertinent to nursing practice are analyzed—for example, the relation of nurses to authority, stereotypes, etc.

This text is of value in professional nursing education because it covers a wide range of concepts applied to a variety of situations that come to the attention of nurses. The work would be strengthened by more careful definition of some of the concepts presented—the concept of integra-

tion, for example. The assets of this work, however, are greatly enhanced by the fresh approach used in the text, by several useful appendices and by an excellent index.—HILDEGARD E. PEPLAU, R.N., ED.D., Rutgers University College of Nursing

FAMILY LIFE SOURCEBOOK

Oliver E. Byrd, Ed.D., M.D.

Stanford, Calif., Stanford University Press, 1956. 371 p.

Viewed in its over-all and long-run perspective, the dominant American family proceeds through a series of stages. Into the family children are born and socialized; then they fall in love, marry and veer away from their aging parents to repeat the process and to keep the cycle rolling down through the generations.

In the perspective of the family life cycle the editor of this *Sourcebook* summarizes 400 articles and reports. Breaking in at the child-rearing stage of the cycle, the compiler summarizes selected articles dealing first with courtship, marriage, pregnancy and child-birth. The succeeding subjects deal with infancy, childhood, normal and delinquent adolescence and with older members of the family. Additional content deals with the family as a unit, family health, broken homes and family-community relationships.

The technique of presentation is the Readers Digest type of condensation of articles selected from 142 professional and semi-professional journals published in the United States since 1940. The average length of these digests is about three-fourths of a page. Each of 13 divisions or chapters of the book opens with a 2- or 3-page overview of the ensuing content. The volume ends with a bibliography of the 400 selected references and an alphabetical list of their sources. Bibliographical references and digests are numerically keyed together for easy use. Author and subject indexes are included.

It is obvious that a compilation and digest of such magnitude represents a prodigious amount of time and effort. In his brief preface the editor indicates that he read 4,000 articles in his search for the chosen 400. A tally of the dates when those chosen appeared in print show that the vast majority were published after 1949, with most appearing during 1954 and 1955.

A careful review of this series of condensations indicates that in general the original articles were prepared by authors who represent high levels of sophistication in research, observation and clinical experiences. Insofar as the *Sourcebook* is a digest of reliable information and valid conclusions pertaining to family life it is a most useful work. It will give the reader access to the gist of pertinent material from widely scattered sources, many of them not readily accessible to the average reader. It will enable the scientific student of the family to identify articles he may wish to read in their original form.

Works of this kind are almost inevitably subject to criticism. They often suffer from inadequate organization, disunity of subject matter and uncertain criteria in the selection of articles for inclusion. Using the family life cycle as his model, Professor Byrd has met the problem of organization quite well. His selections fit quite neatly into the several stages of the cycle. The matter of coherence and unity is less adequately managed. The pages introducing each chapter of the book turn out to be no more than series of short paragraphs which attempt the ultimate in condensation—the summarizing of the summaries that follow.

Perhaps the major unanswered question about this digest concerned the criteria by

which the editor selected his articles for condensation. It may be assumed that many originals were rejected because they failed to fit the outline adopted for the book. Still the discerning reader who is widely familiar with materials in the field of family life education and research will wonder why certain articles of outstanding excellence are omitted while articles of lesser merit, in his own view, are included.—A. R. MANGUS, Ph.D., Ohio State University

ANXIETY IN CHRISTIAN EXPERIENCE

By Wayne E. Oates

Philadelphia, Westminster Press, 1955. 156 p.

There is a continual need for books to interpret different aspects of psychiatry to members of other professions. This one, by the professor of psychology of religion and pastoral care at the Southern Baptist Theological Seminary in Louisville, is intended to aid Protestant clergymen in counseling their parishioners.

The author is well read, quoting Freud, Sullivan, Rank, Maxwell Jones and others. His case examples are varied and illustrative. The theological technical terminology would make it difficult for the majority of laymen. Many relevant passages from the Bible are given.

One pleasing thing about the book is that sources of anxiety are classified and discussed under more headings than the usual ones of sex and aggression. The discussions of what the reviewer has called "cosmic" anxiety, including those arising from increasing age and approaching death, are excellent. There is also a wisely cautious chapter on the "morally indifferent," whose lack of anxiety and compunction often permits them to exploit a clergyman's Christian conscience. It is surprising that Jung is not cited, when he has written more about religion and psychiatry than almost any other.

Unfortunately there is no index.

This volume is recommended highly for clergymen struggling with the everyday problems of their parishioners and for those who work with clergymen on such cases.—ROBERT A. CLARK, M.D., Philadelphia

A BELIEF IN PEOPLE

By Margaret E. Rich

New York, Family Service Association of America, 1956. 190 p.

The motive to help one's fellow in need is doubtless as old as mankind. The method has been the variable. To give help in the way that will do the most good to the individual and to the society of which he is a part has never lent itself to an easy answer.

It was a new method of organizing charity that marked the beginning in this country of the family social work movement, the history of which is set forth in *A Belief in People.* The idea of the first Charity Organization Society in this country, established in Buffalo in 1877, and of many others that followed was to bring order out of philanthropic chaos by organizing "all existing charitable relief agencies into a working whole for the better division of labor and the more effective aggregation of effort." With this community organization emphasis went two basic principles: (1) to see the individual behind the need and to help the poor help themselves in preference to doing things for them; (2) to discover and remove the causes of poverty with special attention to housing, social and sanitary reforms.

There was a firm conviction that scientific charity could "cure the misery of those

who suffered now and work constantly toward such improvement in circumstances that the number of the miserable shall diminish day by day." The scientific approach was in sharp contrast to the thoughtless and haphazard relief-giving then so prevalent.

A Belief in People recounts the evolution, from these origins, of family social work, now represented by some 265 agencies banded together in the Family Service Association of America. Significant developments to which these agencies and the national association have contributed in large part, as this history shows, include the following: method and practice, from the early principles of investigation to guide the "friendly visitor" through the great contributions of Mary Richmond and her classic *Social Diagnosis* to modern social case work; training courses leading to schools of social work and the emergence of a profession; emphasis upon the family and family relationships in treatment and prevention; continuing interest in the improvement of social and living conditions, especially those under which family life can flourish; transition from a strong feeling against public outdoor relief as it was administered in the early days to the effort to develop public assistance according to the best standards, beginning with the depression of the 30's; today's outstanding role of the family agency in providing skilled professional service on personal and family problems for people of any economic group; development of research in social work.

In its direct concern with human behavior and human relations and with the role of the family in the molding of personality the family service field is shown to have a close kinship with that of mental health.

A Belief in People is both authentic and readable. Fortunately it was written by Margaret E. Rich. Her career, dedicated to family service in the Boston and Pittsburgh agencies and for many years in a post of top leadership with the Family Service Association of America, helped to make the history she records. Always an articulate spokesman for the field, Miss Rich rendered it a final and pre-eminent service in the preparation of this volume which she completed only a few weeks before her death on May 6, 1956.—STANLEY P. DAVIES, Community Service Society of New York

FIVE HUNDRED OVER SIXTY; A COMMUNITY SURVEY OF AGING

By Bernard Kutner, David Fanshel, Alice M. Togo and Thomas S. Langner

New York, Russell Sage Foundation, 1956. 345 p.

This study of 500 non-institutionalized men and women over 60 concerns itself with (1) their problems of personal adjustment, (2) factors affecting or affected by their health, (3) their use of community health services and (4) their attitudes toward health and social centers. The study was made with the hope of finding the answers to three questions: What social and cultural factors facilitate adjustment to aging? What kinds of people successfully adjust themselves to aging? What forms should be taken by programs designed to serve the needs of the aging?

The area selected for the study was a part of New York City where persons from almost all socio-economic levels were to be found, and its inhabitants included people of diverse cultural and racial backgrounds. The district was served by a welfare center, a health center, a visiting nurse, a branch of a family case work agency and a local settlement house. Other organized welfare services were carried on by various ethnic and religious organizations. There was an

abundance of social clubs, nationality societies and local church groups. This complex area was chosen because it was felt that the problems presented by the older people here would be so varied that the findings, either general or specific, would have wide application in other areas.

A most comprehensive field survey questionnaire was used as a guide for the interview to secure information from the older people themselves—and most revealing information it is. For instance, there seem to be marked differences in the adjustment of the married, the single and the widowed. The importance of employment as a morale factor, particularly for men, is clearly brought out, especially when the individual lacks the self-sustaining interests and necessary flexibility to redirect his life to offset the concomitants of aging.

The health picture as reported by these 500 aging men and women is surprisingly good. Fifty-six percent had good health, 26% fair and 17% poor health, with more illness reported as the economic level decreased. Many of those who report themselves in poor health did not seem to feel handicapped by it. The attitudes of these people toward using health services, advisory services and social clubs are also statistically evaluated and there seems to be marked evidence that "if programs of services for older people are effectively to reach those who are inclined to use them, such services must be as diverse and embedded in as many organizational contexts as there are preferences, attitude patterns and values regarding aging among the older population."

The data presented are interesting, but it is the authors' pertinent questions as to the significance of the data which cause one to think. Needs are evident, but to bring the service and the elderly person together is indeed a challenge. For example, the sons and daughters of the aged person come to a social agency for counseling regarding the parent, but the elderly person very rarely presents himself to a social agency for help in problems of adjusting to his circumstances.

The authors point out that mental illness among the aging is a paramount problem—yet there seems to be little time for psychotherapeutic work with aged patients. Nor have psychiatric skills been adapted to the particular problems and circumstances of the older people. In other words, mental health and other services are not geared toward preventive services with the aging. This is particularly unfortunate as the older person "is pressured out of the labor force, is often faced with diminished financial resources and a lowered standard of living, with a continuous reduction of social ties because of the death of peers and loved ones, and with the emotional impact of waning physical vitality in a culture emphasizing youthful beauty and youthful vigor."

This is a revealing and a challenging book. It shows clearly the situation of the aging in a portion of New York City, which probably has as many if not more resources for the health and welfare of its inhabitants than most large cities. It is a situation which needs action. The authors point out obvious and immediate needs as well as those requiring further research before plans can be developed to meet them wisely —among other things, a new definition of the aged not related to chronological age but to the individual, his abilities and capacities and his needs to use these productively and fully.

This is a study which produced answers in good measure to the questions it originally raised. These answers are important to everyone from architects and employers to welfare and health agencies, whose attention has been focused chiefly on the older

people with serious illnesses rather than on preventive work which will enable many to have fuller and happier lives.—HESTER B. CRUTCHER, New York Department of Mental Hygiene

MENTAL HEALTH ASPECTS OF SOCIAL WORK IN PUBLIC HEALTH

By Gerald Caplan

Berkeley, University of California School of Social Welfare, 1956. 293 p.

In this report of the proceedings of an institute on the mental health aspects of social work in public health, Dr. Caplan reveals brilliance as a teacher as well as a rich background and experience in clinical psychiatry and research. His presentation of theoretical content on personality development and mother-child relationships is well organized and is made easily understandable by homely illustration from the everyday experiences of doctors, nurses and social workers.

Membership in the institute was restricted to social workers employed in public health agencies or schools of public health. The pattern of work was the presentation of theoretical material followed by discussion periods in which Dr. Caplan became a resource person. By giving a nearly verbatim report of Dr. Caplan's remarks, the editor succeeded in preserving the interchange between him and members of the group.

The theoretical presentation focused on the information that is essential to an understanding of maternal and child health and the means by which it may be applied in preventive mental health work with emphasis on the consultation method.

Description of the development of personality, while based on accepted concepts of dynamic psychiatry, stressed the continual interaction between the individual, his family and the cultural group to which he belongs. There was discussion of the ways in which individuals handle stress situations by mobilizing their strengths and by relying on external support from their family and culture. The goal of mental health workers is to help individuals regain lost emotional equilibrium by healthy adaptive processes.

There was considerable discussion of the emotional implications of pregnancy because of the importance of this period of disequilibrium for the promotion of healthy mother-child relationships, at least in the first months of the child's life. With a weakening of the early symbiotic relationship the mother and child become affected by each other's behavior and it is still not possible to predict whether preventive work during pregnancy can modify their later relationship. Some practical, useful suggestions are made for handling women of different personality types and for helping in such guilt-laden situations as attempted abortion and the birth of a malformed child.

Throughout the discussion Dr. Caplan focused on increasing the understanding of social workers to facilitate their handling of such common problems as the geographic separation of mother and child and necessary hospitalization in terms of the maintenance of family equilibrium during these and similar stress periods. He pointed out that these crises are not psychiatric conditions but rather part of the ordinary experience of living and continuous adjustment.

The consultation method described by Dr. Caplan was developed in Israel and at Harvard University, chiefly for mental health consultants to use with teachers and child care workers in crisis situations. The

objective is to restore equilibrium in a minimum amount of time, by freeing the consultee from his own emotional conflicts and "blind spots" so that he is able to help the client without undue personal involvement. Consultation techniques were discussed in considerable detail with elucidation of some of the administrative and relationship problems commonly encountered.

The report of the proceedings includes a description of the family health clinic conducted by the Harvard University School of Public Health. Four previously published papers by Dr. Caplan in the appendices provide background material to the discussion. A bibliography of publications referred to in the discussion would have been a useful addition.

These institute proceedings deserve wide use as teaching material for mental health consultants and for those responsible for the organization and content of interdisciplinary mental health conferences. Schools of public health, nursing and social work as well as state and local departments of health and mental health will find this report a valuable mental health resourse.—HELEN SPEYER, New York City Community Mental Health Board

CASE STUDIES IN CHILDHOOD EMOTIONAL DISABILITIES

Edited by George E. Gardner, Ph.D., M.D.

New York, American Orthopsychiatric Association, 1956. Vol. 2. 368 p.

The second volume of these studies in childhood emotional disabilities should amply fulfill the hopes of the editor, Dr. Gardner, that these studies will serve a useful place in teaching and training. The scope of the case studies presents ample variety and a good distribution from the standpoint of geographical area and point of view.

Possibly the most interesting aspect of these case studies to the reviewer is the cross-sectional view given of the trends in cases coming to psychiatric clinics today. The studies reflect the current prevailing impression that younger and more seriously disturbed children are presenting themselves for treatment in increasing numbers. The volume also bears out the impression of a continuing shift in the pattern of disturbances from behavior disorders toward conditions of severe neurosis, psychosomatic disease and psychosis. Because these case studies appear to verify these trends, they should be doubly important in teaching for those who are training to meet the changing needs of the field of childhood emotional disorders.—JOHN A. ROSE, M.D., Philadelphia Child Guidance Clinic

THERAPEUTIC EDUCATION

By George Devereux

New York, Harper & Brothers, 1956. 435 p.

The preparation of this book was stimulated by the author's study of 15 students who in the opinion of the Devereux school administrative staff had failed to respond to the school's program. The study of these students had some interesting results. It led the author to examine the basic meaning of education, the process of socialization or of "humanization" and "ethnicization" as he labels it, the place of the family in the education of the child and the meaning of all this for a school in which the mentally and emotionally disturbed or defective children are to be guided.

The difference between therapeutic education and psychotherapy is one of the

major themes that runs throughout the book. The author writes from a psychoanalytical background and this gives a particular coloring to the discussion. Psychoanalysis when applied to disturbed children is thought of as an "unlearning" of the deviant patterns. Following such "unlearning" the child learns more "adequate" ways of using his potentialities by living in a specially planned social and cultural milieu under the guidance of a "therapeutic educator." Thus the functions of the "psychotherapist" and of the "therapeutic educator" are truly complementary.

The aims and processes of therapeutic education are examined in considerable detail. The process culminates in a creative discipline in which the child has ample opportunity and encouragement to realize his potentialities and this in effect makes "ego-restricting" punishment unnecessary.

Further exploration of the process of therapeutic education leads to the realization that the adjustment of the therapeutic teacher himself is of utmost importance for he must be emotionally free to view each child objectively and, no matter how different, help him develop his capabilities. It also leads to the realization that too often the patient is not the child but the parent. Finally, society's attitudes toward the exceptional child also often constitute an obstacle to effective reeducation.

Throughout the book the author supports his principal contentions with numerous excerpts from case histories. His method is to report individual cases rather than rely on experimental tests using groups of subjects.

This analysis of the process of educating the disturbed or defective child will be of particular interest to workers in the area of special education. The discussion of the distinctions between psychoanalysis and therapeutic education will be of interest to clinicians as well.

Although one may find it difficult and sometimes unnecessarily tedious to follow the author's thinking the desire to examine the education of disturbed children in terms of basic educational and developmental considerations is a worthy aim.—RALPH H. OJEMANN, University of Iowa

MENTALLY HANDICAPPED CHILDREN: A HANDBOOK FOR PARENTS

London, National Association for Mental Health (England), no date. 88 p.

Mentally Handicapped Children, a handbook for parents, was published by the National Association for Mental Health of England. It is a pocket-size book dealing with four areas of parent education—facing the truth, medical questions, basic home training, and teaching the child at home. The four contributors are from the fields of psychiatry, psychology and education and from the description of scholastic degrees and professional affiliations they should be authorities on the subject they treat.

Writing a book for parents on a professional subject presents a number of problems. To be of any value it must be readable, long enough to adequately treat the subject matter and sensitive to the emotional needs of the parents. It must also be consistent in its approach and must define accepted technical terms in meaningful language within the comprehension of parents. Above all, it should offer instructive help in gaining the insight necessary to resolve the many personal problems resulting from having a mentally deficient child in the family.

Although this book has a number of helpful hints for parents who are obliged to keep their children at home, it lacks a consistent approach and an understanding of accepted educational principles to make it truly valuable. The approach to home teaching is somewhat artificial and unrealistic and it is doubtful if the authors' recommendations could be followed by American families.

The chapter on medical questions has some good information which may help to answer a number of disturbing questions parents face concerning the medical aspect of mental retardation.

Because this book was written for English parents, American parents of retarded children may find the language somewhat confusing and not too helpful.—VINCENTZ CIANCI, Morris County (N. J.) Department of Education

THE URGE TO PUNISH: NEW APPROACHES TO THE PROBLEMS OF MENTAL IRRESPONSIBILITY FOR CRIME

By Henry Weihofen

New York, Farrar, Straus and Cudahy, 1956. 213 p.

This volume considers and discusses most of the recorded argument in favor of or against abolition of the M'Naghten rule. This test of mental irresponsibility for crime, devised by the English court in 1843, remained the sole test in that country and in 29 states of this country until in 1953 the Court of Appeals for the District of Columbia, in the case of Durham *vs.* United States, discarded the rule and applied the product rule in an important decision.

From the inception of the M'Naghten rule Dr. Isaac Ray criticized it in his books and urged adoption of a principle that in criminal cases insane persons should not be held responsible for their criminal acts unless the acts are proved not to have been the direct or indirect result of the insanity. Nonetheless the older "capacity-to-distinguish-right-from-wrong" test prevailed in most jurisdictions until 1953. True, in 1869 the New Hampshire court approved a charge given by a trial judge in a criminal case to the effect that "all symptoms and all tests of mental disease are purely matters of fact to be determined by the jury" and that "if they found that the homicide was the product of the mental disease, they should find the defendant not guilty by reason of insanity." But this so-called "product rule" was not adopted elsewhere until the Durham case formulated a rule not unlike that of the New Hampshire court. The interest aroused by the Durham decision may be seen in the many articles concerning it in law reviews and medical-legal journals, re-evaluating the M'Naghten rule.

Professor Weihofen points out the many frustrating blind alleys encountered when a psychiatrist is required to present his opinion of sanity in the language of the law rather than in the language of his profession. His diagnosis, not being drawn from considerations of right or wrong in a legal sense, has no meaning to him when forced into those terms. How then can it be expected to aid the jury?

On the other hand, the primary objection against the product rule seems to be that it would submit the insanity defense to the jury without giving them the guidance of any definite formula or criterion. The answer to this, it is argued, is that juries disregard the technical M'Naghten rule anyway and if they are convinced that the defendant was seriously disordered and that it was this fact that led to the crime they will usually acquit, no matter how they are charged.

The model code of the American Law

Institute dealing with provisions for mental irresponsibility is also reviewed and compared with the two other rules generally in use. This is considered to be a middle-of-the-road approach, adhering to the essence of the right-and-wrong test of the M'Naghten rule but supplementing that test by adding impairment of volitional capacity as a defense. This too, it is stated, fails to bridge the gap now existing between legal and psychiatric thinking. The psychiatrists are convinced that the premises of the law, dealing with "insanity" as a defense, are unsound and indeed that we must rid ourselves of the idea that any clear and definite test of "insanity" is either possible or desirable. We are seeking not psychological precision, states the author, but the jury's judgment in the light of an adequate picture of his mental condition as to whether the defendant should justly be held responsible and so punishable.

This book is worth the study of both the professions. The detailed discussion of problems encountered in applying each of the rules and the attempts now being made to utilize medical research in this field to resolve this ancient problem of the law can be of great value to the practitioner.—JUDGE LUTHER ALVERSON, Atlanta

PRINCIPLES OF PSYCHOLOGICAL EXAMINING; A SYSTEMATIC TEXTBOOK

By Frederick C. Thorne, M.D., Ph.D.

Brandon, Vt., Journal of Clinical Psychology, 1955. 494 p.

This book may be employed as a complementor and/or supplementor to the author's previous work, *Principles of Personality Counseling.* The present volume was a long time in the making and provides a sound base of operation for the materials contained in the first book.

Dr. Thorne, who is the well-known editor of the *Journal of Clinical Psychology,* hits the nail on the head in the opening remark in the preface: "The cornerstone of all clinical work is valid and reliable diagnosis." Clinical judgment can be subjected to a rigorous scientific test only if sound diagnostic methods are available. Especially is this true when we keep in mind that differential diagnosis depends to a large extent on the clinician's ability to locate and identify relevant variables pertaining to the behavior in question. Dr. Thorne stresses the meaning of this phenomenon by reminding us that while each person is different there is a "wholeness" about personality. Furthermore, not all factors involved in a psychological field at any given moment are easily revealed or exert equal etiological influence in behavior.

The author does not permit us to forget that interpretation of objective tests can carry with it the seeds of the interpreter's own frame of reference. The situation becomes more difficult when one realizes that interchanging psychological test reports between examiners and clinicians is often handicapped by these theoretical biases plus a host of semantic differences.

This volume is very thought-provoking. Dr. Thorne's contribution has come about as a result of much serious consideration about vital concepts in human behavior. Thus sentence after sentence strikes home with amazing clarity. Adaptive value of habits, among other things, is indicated as being of importance in carrying a person through trying situations that threaten personality integration. The author emphasizes that even in retirement the person should be enabled to work at those avocations which have been of most enjoyment.

This work is a most worth-while effort.

The material it covers is of immense value when we stop to realize the following: Behavior organization becomes more complex as the individual participates in situations and is forced to select structures of reaction which may be contradictory in meaning and in value. A carefully thought out volume such as *Principles of Psychological Examining* forces us to sharpen our senses in knowing whereof we speak as clinicians and workers in mental health.—ARTHUR LERNER, Los Angeles City College

Notes and Comments

MRS. DUPONT NAMED TO HEAD VOLUNTEERS

At the invitation of the board of the National Association for Mental Health, Mrs. A. Felix duPont, Jr., of Wilmington, has accepted appointment as national director of volunteer services.

In her new volunteer post she will spearhead the recruitment and development of volunteer leadership throughout the mental health movement and will guide state and local mental health associations in broadening their volunteer services to mental patients and their families and to the community.

One of Mrs. duPont's first activities will be to recruit experienced leaders—both men and women—for a new NAMH committee on volunteers. As state mental health associations appoint their committees on volunteers she will work with the state chairmen in developing sound standards for the selection, training, placement, guidance and recognition of volunteers for many mental health assignments.

Besides serving on mental health association boards and committees, mental health volunteers will be recruited to provide a variety of services for hospitalized mental patients, to help discharged patients resume their place in the community, to work with families of patients, serve as discussion leaders for educational programs, work in clinics and perform many functions in mental health association offices and information centers.

Mrs. duPont's own service as a mental health volunteer has been varied. At present she has a regular assignment at Delaware State Hospital, where she serves in the music room and library. She is also a board member of both NAMH and the Mental Health Association of Delaware, and vice-president for Region 1. In 1955 she was national chairman for the Mental Health Campaign. In addition she has served as chairman of the NAMH nominating committee, president of the state association and chairman of its nominating, education and volunteer committees.

In her new assignment she will have the assistance of Miss Mary Mackin, who joined the NAMH staff last fall after long experience in organizing and developing local and national volunteer services.

PROMOTION FOR DR. FELIX

Dr. Robert H. Felix, director of the National Institute of Mental Health, has been promoted to the rank of rear admiral, with the title of assistant surgeon general of the U. S. Public Health Service.

SCHEDULE SET FOR ADVERTISING DRIVE

The Advertising Council's nation-wide public information program on mental health, undertaken in cooperation with the National Association for Mental Health, will get underway in June.

It will consist of a year-round series of informative mental health messages reaching the public in the form of free advertisements by TV, radio, newspapers, outdoor billboards, transit cards and house magazines. Advertising contributed for the program by business firms and by the owners and operators of advertising media will reach an estimated value of approximately $6,000,000 a year for two successive years.

Each advertisement will draw attention to the importance of some aspect of mental health and offer the viewer or listener a free booklet. This booklet, prepared by NAMH and distributed by the Advertising Council, will:

- Suggest ways of dealing with the tensions and anxieties of everyday life.
- Suggest how to go about getting help for mental and emotional disorders that are deeper than ordinary, everyday tensions.
- List publications offering additional information on specific mental health problems.
- Refer the reader to his state mental health association for additional information and guidance.

The mental health information program will share a huge pool of contributed time, space and facilities in the various media with 17 other drives backed by the Ad Council.

Most national TV and radio advertisers, many regional advertisers and all major networks will cooperate in the information program by broadcasting mental health messages on an assigned schedule. For TV, the Advertising Council will provide a variety of visual materials such as slides, films and projection cards.

Mats of large display ads will be made available by the council to the advertising managers of all daily and several thousand weekly newspapers throughout the country. The newspapers will either run these ads as a public service or ask local advertisers to sponsor them.

Twice a month the Ad Council also supplies cooperating daily newspapers with a choice of two mats of small ads on one cause. Beginning in June this cooperative plan will include mental health.

Editors of industrial house magazines will be supplied on request with both ads and editorial features. Posters will be distributed to local outdoor advertising companies, and transit ad cards will be sent all over the nation for use in trains, trolley cars, buses and subways.

The schedule follows:

Newspapers

Proof kits: June and October
Cooperation plan publication dates: June 25, August 6, October 1 and December 24

House Magazines

July-August issue
November-December issue

Car Cards

June and December

Posters (3-sheets)

July and August

Radio

Radio kit: August
Time allocations: July, September and November

Television

TV kits: July and November
Time allocations: July

The National Association for Mental Health will supply information on mental health, along with psychiatric guidance and counsel in adapting the information to various advertising formats.

The Advertising Council is a non-profit business organization which serves the public interest by marshalling the forces of advertising to help solve national problems. The public information program on mental health is the first undertaken by the council in behalf of a health cause.

TO VISIT HOSPITALS

A private citizens' group will periodically visit and inspect the 27 institutions of the New York state mental hospital system under a plan announced April 4 at the annual meeting of the New York State Society for Mental Health.

Known as the New York State Citizens Advisory Group for State Mental Hospitals and Schools, it will work to increase public knowledge and understanding of the institutions and the problems of mental disorder. Existing legislation provides for this traditional citizens' activity by components of the State Charities Aid Association, of which the mental health society is a part.

Teams of visitors will call at the institutions to observe physical facilities, services being rendered to the patients, and hospital-community relations. They will periodically report their observations to the directors of the state mental health society, and the information will be transmitted to the institutions and to the State Department of Mental Hygiene.

The group will consist of both professional workers and laymen, with the latter predominating. It will be a standing committee of the mental health society and will be expanded as needed. The program is being financed initially by special foundation grants and will eventually get its support from the annual public campaigns for funds for mental health.

GRANTS FOR SEMINARS

The Joint Commission on Mental Illness and Health is awarding 15 small grants this year to encourage seminars on topics bearing on mental illness or health. Up to $750 to cover secretarial expenses, the preparation of bibliographies, publication costs or related expenses will be allocated through universities to individuals in departments of anthropology, psychiatry, psychology, social work and sociology and to interdisciplinary groups.

The commission is giving preference to seminars most likely to produce publishable reviews of the literature on some significant problem in the field or to those reviewing the literature to identify gaps in knowledge or to define promising new leads.

Applications giving pertinent information about the purposes, personnel and budgetary needs of such seminars should be addressed to the JCMIH, 808 Memorial Drive, Cambridge 39, Mass.

NAMH HONORS NINE

The National Association for Mental Health has elected the following honorary members:

Frank Bane, executive director, Council of State Governments; Dr. Robert H. Felix, director, National Institute of Mental Health; Dr. Frank Fremont-Smith, medical director, Josiah Macy, Jr., Foundation; Walter D. Fuller, chairman of the board, Curtis Publishing Company; Dr. Ira V. Hiscock, chairman of the department of public health, Yale University School of Medicine; Dr. William C. Menninger, general secretary, Menninger Foundation; Dr. Arthur H. Ruggles, formerly superintendent, Butler Hospital, Providence, R. I.; Dr. Benjamin M. Spock, professor of child development, University of Pittsburgh School of Medicine, and Dr. M. A. Tarumianz, superintendent and director, Delaware State Hospital.

STUDY CONDEMNED MEN

Governor Averell Harriman has enlarged the New York Prison Commission from 5 members to 9 to make possible more thorough psychiatric studies of prisoners condemned to death for murder. The commission reports to the Governor on the sanity of condemned slayers appealing for clemency.

MENTAL HYGIENE readers will recall the historic decision of the U. S. Court of Appeals for the District of Columbia, handed down July 1, 1954, regarding the relation between mental illness and responsibility for criminal acts. MENTAL HYGIENE published the Durham decision, praised by psychiatrists and jurists alike, in the April 1956 issue, along with a commentary by Dr. Julius Schreiber of Washington, D. C.

RESEARCH

The Ford Foundation announced March 2 that $14,153,399 of the $602,000,000 it disbursed last year went to programs in mental health research and other activities in the behavioral sciences.

Of this sum, $6,826,850 went to 21 mental health research centers in the United States for use over a 5-year period. A grant of $3,682,000 went to the Foundations' Fund for Research in Psychiatry, New Haven, to develop a training program which includes fellowships, additions to research staffs and the establishment of senior research professorships. A grant of $210,000 also went to the Mental Health Research Fund of London for research and research training in the United Kingdom.

The grants cover a wide range of institutions, including medical schools, hospitals, research institutes, universities and a technological institute. Among the disciplines represented in research projects approved so far are anatomy, physiology, pharmacology, neurochemistry, psychiatry and psychology.

The Youth Board Research Institute of New York received $105,000 for applied research in juvenile delinquency. The institute is working on a 7-year study of methods of early identification and treatment of potential delinquents based on measurements devised by Drs. Sheldon and Eleanor Glueck of the Harvard Law School whose work also has received assistance from the Ford Foundation.

An additional $3,200,000 was committed for other projects in the behavior sciences. Support of research in international communication at the Center for International Studies, Massachusetts Institute of Technology, and the program at the Center for Advanced Study in the Behavioral Sciences was continued. Grants for long-term basic research projects in anthropology, psychology and sociology, as well as a program of research grants-in-aid to 63 individual behavioral scientists also were approved.

* * *

The possibility that the life potential of the central nervous system is considerably greater than the average life span in America today highlighted a recent conference of 30 leading researchers in the field of neurological and sensory disorders. Dr. Edmund V. Cowdry, research professor of anatomy at Washington University, St. Louis, was honorary chairman for the meeting, held in January at the National Institutes of Health.

Discussions underscored the hope that the aging process might eventually be susceptible to some measure of control or guidance

by scientific means. "The fact that people age at varying rates in the physiological sense," Dr. Cowdry said, "is of particular relevance in this connection."

Conferees termed the meeting "a pioneering venture which has opened the way to a coordinated attack against the problems posed by the process of aging in the nervous system."

Some noted that recent animal studies demonstrate there is no significant loss of nerve cells as a result of aging. This may indicate, they said, that the central nervous system is capable of life well in excess of the present life span.

The conference heard the results of a series of experiments, involving both man and animals, designed to probe the relationship between age and neural responses. The experiments made it possible to test reactions to a number of different types of stimuli. The evidence was conclusive that aging of the nervous system is marked by slowing in the speed of integration of behavior such as is seen in skilled acts. This change in speed of response seems to be one of the most fruitful points on which to focus further research.

In discussing the relationship between aging in the nervous system and the cerebral vascular system, some conferees felt changes in the blood circulation system of the brain (such as arteriosclerosis) did not unduly influence the aging process in the nervous system. There was general agreement that vascular changes were not the only factors bearing on aging in the nervous system.

A detailed scientific report of conference proceedings will be issued later this year.

* * *

Psychiatrists of 18 countries have agreed to cooperate on transcultural studies being put into operation by McGill University's department of psychiatry.

The first project, initiated last year at Lima, Peru, deals with the relative significance of psychological, socio-cultural and physiological factors in the etiology of psychosomatic disorders arising from the movement of Highland Indians to coastal cities. Co-sponsors are McGill's departments of psychiatry and of sociology and anthropology in association with the department of psychiatry of the Hospital Obrero in Lima.

A second project is publication of a newsletter containing information on transcultural studies derived from psychiatrists in many countries. Dr. E. D. Wittkower of Allan Memorial Institute, Montreal, is in charge.

* * *

Preventive mental health measures among pre-school children are proving practical at the New York School for Nursery Years, which is conducting a 3-year study of case work services in a nursery setting, under a grant from the Field Foundation.

One out of four typical pre-school children has some mild behavior difficulty that needs attention to prevent future problems, the school has found. In the "overwhelming majority" of instances a trained case worker can help clear up the difficulty either through guidance to parents and teachers or through direct work with the child.

The project, developed jointly by the New York School for Nursery Years and the New York School of Social Work, is the first fully integrated collaboration in this country between a nursery school and a school of social work.

Behavior patterns of children 2 to 5 years old often differ at home and at school, according to the study. "Certain children who were problems to their parents because of their food habits exhibited no difficulties while eating lunch at school and actually

seemed to enjoy the same foods they rejected at home. Others observed to be very aggressive in the class were reported by their parents as well-mannered, quiet and showing no signs of aggression at home."

The study has shown that in a nursery school a new way of functioning has developed for the case worker. A large part of her work is in the classrooms, getting to know the children and working closely with teachers.

* * *

A Center for Aging Research has been set up in the National Institutes of Health with Dr. G. Halsey Hunt as director. Part of the U. S. Public Health Service's effort to coordinate and accelerate all its activities in the field of aging, the center will aid universities, medical schools and other research organizations in establishing comprehensive research centers on aging, to be supported in part by research grants from the NIH.

In addition, the Ford Foundation has granted $500,000 to the National Social Welfare Assembly's committee on the aging. The committee, formed five years ago, will use the grant to conduct a consultation service for state commissions and community groups interested in the problems of the aged.

It is predicted that by 1975 there will be more than 20,000,000 people 65 and over as compared with about 3,000,000 in 1900 and 12,000,000 in 1950.

* * *

The National Association for Mental Health is the first citizens' voluntary health group to join with Congress and the National Institute of Mental Health in subsidizing the 3-year mental health study being made by the Joint Commission on Mental Illness and Health.

Dr. Harold W. Elley of Wilmington, NAMH board chairman, transmitted a $5,000 check to Dr. Kenneth E. Appel of Philadelphia, Joint Commission president. Dr. Elley said NAMH was taking this means of expressing its "great enthusiasm for the way the Joint Commission on Mental Illness and Health is attacking the problem."

The commission, made up of representatives from 27 national agencies concerned with some aspect of mental health, is a nongovernmental agency operating under congressional authorization and annual grants from NIMH. It is now in the second year of its multi-faceted analysis and evaluation of the nation's resources for fighting mental illness and promoting mental health. The staff, with headquarters in Cambridge, Mass., has 10 study projects well under way. The commission hopes to add more projects in 1957 if further support becomes available.

* * *

Grants for special mental health projects have become available under a 1956 amendment to the U. S. Public Health Service Act.

According to the National Institute of Mental Health, which is administering the grants, the projects may involve:

- Developing improved methods of care, treatment and rehabilitation.
- Testing the applicability of methods in a hospital or community.
- Demonstrating the feasibility of new methods.
- Developing and establishing improved administrative techniques and practices.

Grants may be made to state or local agencies, both public and private, institutions, laboratories and individuals for investigations, experiments, demonstrations, studies

and research projects affecting the mentally ill or mentally retarded of any age group. Projects should be so designed that they may be reported for the benefit of others.

Special application forms are available from the NIMH, Bethesda 14, Md.

TRAINING

Closed-circuit television will link 3,000 physicians in five states May 6 for a seminar on "The Physician and Emotional Disturbance." Simultaneously they will see psychiatric cases selected to demonstrate the most commonly encountered emotional conditions, such as depression and anxiety.

The hour-long program will connect doctors in North Carolina, Louisiana, Oklahoma, Kansas and Florida with a panel of psychiatrists and general practitioners in Chicago. Moderators in Asheville, New Orleans, Tulsa, Wichita and Hollywood, Fla., will be in direct communication with the panel so that questions from the audience can be answered by 2-way audio hookup.

The "videclinic" will be presented by the American Medical Association's council on mental health and the five state medical societies in cooperation with Smith, Kline & French Laboratories, Philadelphia pharmaceutical firm.

"The importance of recognition by the physician in general practice of emotional conditions, and the prompt initiation of treatment, cannot be over-estimated," the AMA council on mental health pointed out. "His ability to diagnose latent mental illness and ameliorate common emotional disturbances can be significant in reducing the incidence of mental disease in this country. We feel that postgraduate instruction in this important problem can benefit physicians in all fields of medicine."

Participants in the "videclinic" will include Dr. Andrew S. Tomb of Victoria, Tex., chairman of the American Academy of General Practice liaison committee with the American Psychiatric Association; Dr. C. H. Hardin Branch of Salt Lake City, head of the department of psychiatry at the University of Utah; Dr. E. Irving Baumgartner of Oakland, Md., secretary of the AMA section on general practice; Dr. Leo H. Bartemeier of Baltimore, chairman of the AMA council on mental health, and Dr. C. Knight Aldrich, head of the department of psychiatry at the University of Chicago.

* * *

Specialized training in child psychiatry is available in a number of member clinics of the American Association of Psychiatric Clinics for Children which have received approval as training centers.

Training begins at the 3rd-year postgraduate level with minimum prerequisites of graduation from an approved medical school, an approved general or rotating internship and a 2-year residency in psychiatry.

This training is in preparation for specialization in child psychiatry, especially for positions in community clinics devoted wholly or in part to the out-patient treatment of children with psychiatric problems. At the completion of training, attractive openings are available in all parts of the country. Fellows receive instruction in therapeutic techniques with children in out-patient settings utilizing the integrated services of the psychiatric clinic team. Most of the clinics have a 2-year training period although a few will consider giving one year of training in special cases.

Fellowship stipends are usually in line with U. S. Public Health Service standards —approximately $3,600 and $4,000 depend-

ing upon whether or not the candidate has finished two years or three of general psychiatry before entering the children's program. Stipends come mainly from the Public Health Service but sometimes from state departments of mental health and individual clinics or occasionally from communities at the end of the training. Some fellows may supplement the stipends by taking on other responsibilities locally (for example, part-time work with the Veterans Administration, consultation to social agencies and the like). A limited number of training centers offer higher stipends.

The American Association of Psychiatric Clinics for Children acts as a clearing house for applicants but in all cases acceptance for training is by the individual training centers. Further information may be obtained from Miss Sylvia Lurie, administrative assistant, AAPCC, Room 1300, 10 Columbus Circle, New York 19.

* * *

Catholic University of America will sponsor a workshop on the teaching of psychiatric-mental health nursing June 14–25. Aim is to aid nurse educators, clinical instructors, head nurses and supervisors of general nursing as well as psychiatric and public health nurses engaged in educational or service programs in psychiatry and mental health.

Fordham University's school of education will hold its 3rd annual guidance institute July 8–19. The topic: testing and counseling in schools.

* * *

Telecommunication is saving both money and time by extending psychiatric training from the Nebraska Psychiatric Institute to six affiliated mental hospitals. The sound network joins hospitals in four states—Nebraska, Iowa, North Dakota and South Dakota—which are pooling their efforts to expand mental health education, training and research.

So far the network has carried the institute's weekly visiting lecturer series to three mental hospitals in Nebraska, one in each of the other three states. On signal from the lecturer, each participating hospital cues in visual aids such as slides, flannel board displays, flip charts and enlarged photographs.

The hookup also allows for consultation between doctors at the various hospitals and specialists at the University of Nebraska College of Medicine, as well as for participation by state hospital psychiatrists in the institute's teaching conferences on individual cases. In preparation for each conference the institute distributes to the hospitals a mimeographed summary of the case and a 3-minute sound film of the patient.

This fall the institute will use the telecommunication system to extend its courses for general practitioners, social workers, clergymen and other groups in contact with mental patients.

Though the circuit linking the 7 institutions is almost 1,300 miles long, savings in travel cost and faculty time more than offset the fees charged by the Northwestern Bell Telephone Company for the equipment and its by-the-hour use.

WORLD MENTAL HEALTH

Alcoholism is a growing problem throughout the world and a major mental health issue, a World Health Organization official reported recently.

Interviewed over WNYC by a panel of foreign correspondents representing leading papers abroad, Ronald Morse, WHO public information officer, said studies made by WHO show alcoholism is a growing prob-

lem "not only in those countries where there is a shortage of food."

Emphasizing that WHO is "very much concerned" with all branches of mental health, Mr. Morse decried the lack of skilled medical personnel in all countries, including the United States.

"It is WHO's wish that every country have an adequate number of mental health practitioners and specialists," he said, pointing out that the international health organization has set up an expert committee on mental health, sent consultants to various countries and made surveys. "Certain fortunate countries have been able to do a great deal about diagnosis and treatment of mental illness," Mr. Morse said, "but other's haven't had the trained personnel."

He emphasized that WHO would like to see mental health as a normal part of public health practice in every country.

* * *

England's National Association for Mental Health has established a memorial fund in honor of Dame Evelyn Fox, who died in 1955. It is said that her foresight and vision did more to influence public opinion and the early growth of the mental health services in her country than the work of any other single individual. One of the first to realize that the needs of the mentally disabled could often be met by community care, she was instrumental in initiating and promoting sheltered workshops for the mentally defective and programs for home teaching and boarding-home care. She was also an advocate of child guidance and of psychiatric social work. During World War II she initiated an after-care program for ex-service psychiatric casualties (later embodied in the National Health Service Act) and proposed agricultural hostels for mentally handicapped men, enabling them to make on outstanding contribution to England's war effort. The National Association for Mental Health was the ultimate outcome of her life work.

* * *

A modern Dr. Pinel is helping Jordan build its first mental health services. He is Dr. A. R. M. Labban, mental health consultant for the World Health Organization. In the last three years he has turned the old asylum of Bethlehem into a modern psychiatric hospital, struck chains and shackles from the patients, opened heavy, padlocked doors.

Jordan has about 250 of the 800 mental hospital beds needed for its million and a half people, according to WHO. "Economic development has brought many of the scattered people of the desert from the quiet of the great spaces to the noise of machinery, and from small tribal groups to crowded towns," Jean V. Manevy, WHO public information officer, points out. The task of the new mental health service: to train mental health specialists, see that sick people get modern treatment, and help the government write sound mental health laws.

* * *

The Ontario government's decision to include the mentally ill in its new hospital care insurance plan could be a long step toward finding a solution to Canada's most pressing health problem, according to the Canadian Mental Health Association.

"It will enable new advancements in treatment to be undertaken," J. S. D. Tory, CMHA president, pointed out. "It envisages general improvement of mental hospital services and promises that new approaches to the whole mental health problem will be initiated wherever betterment can be made."

"During the past 25 years," said Mr

Tory, "there has been a gradual disappearance of the idea that a patient can somehow be divided into a body and a mind, with patients suffering from disorders of the body being treated in general hospitals and those suffering from disorders in the mind in mental hospitals. Today more than 20 of the larger general hospitals have established special psychiatric units, and many have diagnostic and outpatient departments for dealing with psychiatric patients.

"Modern medicine recognizes that mental illness is like any other illness; it has causes, it runs a course, it is susceptible to treatment. Our new law recognizes these facts," said Mr. Tory. "This legislation will give a tremendous impetus to the drive for a research program that will do for the mentally ill what Salk did for victims of polio. The need is even greater, for unless we find a solution to the problem of mental illness one in every 12 of our children will spend some time in a mental institution during his lifetime."

MEETINGS

Gov. George M. Leader of Pennsylvania will be the keynote speaker for the 84th annual forum of the National Conference on Social Welfare May 19–24 in Philadelphia. He will speak on the forum's theme, "Expanding Frontiers in Social Welfare."

Since its inception in 1874 as the Conference of State Boards of Public Charities, the organization has aimed at providing a dynamic educational forum for the critical examination of basic social welfare issues. As its sphere of influence broadened the group changed its name—in 1879 to the National Conference of Charities and Correction, in 1917 to the National Conference of Social Work and last July 1 to the National Conference on Social Welfare, considered by most members more accurately descriptive of its aims.

* * *

The American Psychiatric Association will hold its 113th annual meeting May 13–17 in Chicago. About 4,000 psychiatrists and guests are expected.

APA's president, Dr. Francis J. Braceland, psychiatrist-in-chief for the Institute of Living, Hartford, will call the meeting to order and deliver the presidential address Monday morning, May 13. Beginning that afternoon and continuing through Friday, May 17, over 130 scientific papers will be presented reviewing recent developments in psychiatry. Many scientific exhibits, films, symposia and other special features are scheduled.

The public is invited to attend the scientific sessions. A $5.00 fee covers admission for the week.

APA, oldest national medical association in the United States, was founded in 1844 by 13 mental hospital superintendents. It now has nearly 9,400 members comprising the bulk of psychiatrists in the U. S. and Canada. Besides President Braceland, other officers are Dr. Harry C. Solomon, professor of psychiatry, Harvard Medical School, president-elect; Dr. William Malamud, professor of psychiatry, Boston University School of Medicine, secretary; Dr. Jack R. Ewalt, commissioner of mental health for Massachusetts, treasurer.

* * *

The annual meeting of the American Society of Group Psychotherapy and Psychodrama will take place May 17–18 in Chicago in collaboration with the organization's

New York, Michigan and Illinois chapters. Day-long sessions will feature workshops and seminars. Dr. Jules H. Masserman, professor of neurology and psychiatry at Northwestern University, will deliver the presidential address.

* * *

Leading psychiatrists from all parts of the world will meet in Zurich September 1–7 for the Second International Congress for Psychiatry.

Papers will bear on the present status of knowledge about the schizophrenias and will cover basic concepts, treatment, psychopathology, schizophrenia in children, research, social questions connected with the care and treatment of schizophrenia victims and comparative observations among different countries and races. Dr. William Malamud, professor of psychiatry at Boston University School of Medicine, will report on the 22-project schizophrenia research program directed by the Supreme Council, 33rd Degree Scottish Rite Freemasonry, Northern Masonic Jurisdiction, through the National Association for Mental Health.

The Second International Congress of Group Psychotherapy will meet August 29–31, also in Zurich. Dr. J. L. Moreno, of New York City, is president and Dr. W. J. Warner, Mamaroneck, N. Y., is chairman of the American committee.

* * *

"Treatment of the Alcoholic" is the theme of a symposium for physicians scheduled for May 23–24 at the University of Minnesota, under the co-sponsorship of the university and the Minnesota Department of Health. Featured speakers will include Dr. Lorant Forizs, medical director of Florida's alcoholic rehabilitation program, who will lecture on motivating the alcoholic patient and the treatment of alcoholics in groups.

Dr. R. Gordon Bell, director of the Bell Clinic, Willowdale, Ontario, will discuss the nature of alcoholism and the use of drugs in the follow-up treatment of the alcoholic. Dr. Vernelle Fox, medical director of the Georgian Clinic, Atlanta, will speak on the use of the ataractic drugs in the treatment of alcoholism. Other speakers will include Dr. Nelson J. Bradley, superintendent, and Dr. Lloyd Smith, physician, of the Willmar (Minn.) State Hospital, and Dr. K. W. Douglas, superintendent of the Sandstone (Minn.) State Hospital.

The conference is open to all physicians but limited attendance will provide ample opportunity for group discussion. Further information is available from the Center for Continuation Study, University of Minnesota, Minneapolis 14, Minn.

* * *

An institute on correctional psychiatry and group counseling will be co-sponsored by the New York State Departments of Mental Hygiene and Correction at Hudson River State Hospital, Poughkeepsie, May 20–24.

The institute, the first of its kind in the state, will investigate such subjects as the theories of criminal responsibility, preservation of inmates' confidence, the function of special examinations, correct use of observation and the role of psychiatric diagnosis in modern correctional study and rehabilitation.

The principal speakers will be Dr. Winfred Overholser, superintendent of St. Elizabeths Hospital, Washington, D. C.; Dr. Manfred Guttmacher, chief medical

officer for the Supreme Bench of Baltimore, Md., and Dr. Henry A. Davidson, assistant superintendent of Essex County Hospital, Cedar Grove, N. J. A unique feature of the program will be a discussion and demonstration of group counseling methods in a prison setting by Norman Fenton, deputy director of classification and treatment for the California Department of Correction.

The institute will be attended by mental hygiene department psychiatrists and clinical psychologists assigned to correctional institutions and by administrative, education, vocational, counseling and guidance personnel assigned to the institutions by the Department of Correction. At present, 24 psychiatrists and 19 psychologists are attached to the correctional institutions. Full-time psychiatric services are available at Sing Sing, Attica, Clinton and Auburn prisons, Elmira Reception Center and Napanoch Institution for Defective Delinquents.

• • •

The newly elected U. S. committee of the International Conference of Social Work has reported initiating full-scale plans for U. S. participation in the Ninth International Conference of Social Work in Tokyo November 30–December 6, 1958.

"Mobilizing Resources for Social Needs" will be the theme of the conference. More than 2,500 representatives of 55 nations attended the Eighth International Conference last year in Munich.

"Our preparations for the Tokyo meeting include administrative and organizational arrangements and extensive pre-conference study and discussion of issues related to the conference theme," said Melvin Glasser of New York City, U. S. committee chairman. "In the next year the U. S. committee will develop reports, an exhibit and discussion programs dealing with social needs, personal needs, shifts in emphasis created by growth and change in population, available resources, and the problem of priorities."

• • •

Almost 600 community leaders from all over Pennsylvania have unanimously endorsed a 10-year plan for mental health and an increased mental health budget now before the state legislature. Meeting in Harrisburg March 11, they also strongly supported civil service status for professional and technical health and welfare workers.

Pennsylvania's long-range plan grew out of over 25 community studies sparked by mental health associations and other groups, plus recommendations by the American Psychiatric Association and Dr. Robert A. Matthews, state commissioner of mental health. In execution, the plan will shift the focus of the state mental health program from the mental hospital as the chief resource for the care of the mentally ill to community-centered early treatment and prevention.

Governor Leader said he saw in the plan "a mandate as unmistakable as a referendum." He proposed that community leaders and state officials meet together yearly to plan increasingly fruitful cooperation on behalf of the mentally ill.

• • •

Thirty-one of the world's leading research authorities on epilepsy met March 22–23 at the National Institutes of Health in Bethesda, Md., for the Second International Colloquium on Temporal Lobe Epilepsy.

This second colloquium—the first was held in Marseilles in November 1954—was sponsored by the National Institute of Neurological Diseases and Blindness, the

National Advisory Neurological Diseases and Blindness Council, and the International League Against Epilepsy. Conferees from the United States were joined by representatives from Canada, France, England, the Netherlands and Italy, as well as several hundred medical researchers in the epilepsy and related fields who attended as guests.

More than 20 scientific papers were presented on such subjects as the pathological aspects of epilepsy, new concepts bearing on the neurophysiology and electroencephalographic aspects of temporal lobe epilepsy, anatomical findings based upon temporal lobe surgery, and clinical aftermaths of temporal lobe epilepsy.

There are an estimated 1,500,000 Americans with epilepsy. Estimates as to how many of these have psychomotor or temporal lobe epilepsy run as high as 40% but no precise figures are available.

* * *

The role of health workers in all fields in fostering better mental health among those they serve was the topic for the 1957 National Health Forum in Cincinnati March 20–22. Over 400 national, state and local health leaders attended.

Major speakers—notably Dr. David B. Allman, president-elect of the American Medical Association, and Basil O'Connor, incoming president of the National Health Council—emphasized the importance of voluntary collaboration between laymen and the professions to solve the problem of mental illness.

In a concrete suggestion for immediate action throughout the nation, Dr. Jack R. Ewalt, director of the Joint Commission on Mental Illness and Health, proposed that individual communities conduct simultaneous mental health studies supplementing those being carried on by the commission. To assure the compilation of comparable information, he recommended their using a basic blueprint and professionally trained personnel. The commission, he said, will without charge help local community leaders design the study and recruit competent workers to carry it out.

Dr. Ewalt said the blueprint might encompass four major points:

- Nature and extent of the community's mental health problem, taking into account not only those receiving psychiatric treatment in hospitals, clinics or doctors' offices but also the juvenile delinquent, the alcoholic, the improvident and otherwise maladjusted.
- The community's agencies as resources for helping these people (and the adequacy of the agencies' funds and personnel).
- The community's resources and activities for promoting mental health and preventing mental disease—not only health agencies but those building character and the ability to withstand life's inevitable stresses.
- Effectiveness of all these resources and the relation this bears to the socio-economic and cultural features of the community they serve.

An important final procedure, Dr. Ewalt said, would be recommending next steps, based on the information turned up by the study, and formulating long-range goals for the community to work toward.

He estimated a 1-year study would cost smaller communities up to $60,000. Though the estimate sounds formidable, he said, it is small compared to the staggering year in, year out cost of mental illness.

Commenting on Dr. Ewalt's proposal, Philip E. Ryan, executive director of the National Health Council, noted that foun-

dations which must spend their funds locally are a possible source of grants for "competently designed and professionally directed" community mental health studies.

The forum program listed over 100 participants. Other speakers stressed various aspects of the mental health situation in America today.

In the keynote address Dr. Francis J. Braceland, president of the American Psychiatric Association, pointed to the key role played by mental health associations in community campaigns for better mental health facilities and services and in the distribution of mental health information. Dr. Winfred Overholser, superintendent of St. Elizabeths Hospital, Washington, D. C., also stressed that the work of the mental health associations in stimulating the greater activity of the public agencies and in educating the public is "worthy of the highest commendations."

Several speakers noted that mental health is more than the absence of mental illness. As Dr. Margaret Mead, president of the World Federation of Mental Health, put it: "Mental health is a gloriously ambiguous term because it expresses a hope, not a state." The Rev. George C. Anderson, director of the National Academy of Religion and Mental Health, agreed that mental health is a "moving target" and Dr. Fillmore H. Sanford, associate director of the Joint Commission on Mental Illness and Health, said: "It may be useful to conceive of mental health as a social movement as vast and as significant, perhaps, as the Renaissance or the Industrial Revolution."

Dr. Harold D. Lasswell, Yale University professor of law and political science, declared, "We may not be crazier than ever but it is crazier than ever to tolerate craziness." Mental disease co-existing with science and technology means, he said, "accident-prone drivers in chariots of destruction," home accidents traceable to nervous housewives, and a dent in national security as mental illness drains off much-needed skills. Dr. Paul V. Lemkau, director of the New York City Community Mental Health Board, asserted community leaders do not yet realize that mental illness is not a single disease with a single cause, a single cure and a single means of prevention and consequently do not yet realize it is a bigger and tougher problem than many physical diseases.

Dr. George S. Stevenson, national and international consultant to the National Association for Mental Health, stressed factors inhibiting the convalescing patient's successful return to community life. He cited the isolation of many hospitals, which makes community and family contact difficult; inadequacy of hospital social service staffs; variance in family customs and values as to obligations toward one's relatives; the stigma attached to mental illness, "which we protest against with our right hand and perpetuate with our left"; general deficiency of clinical, vocational and social rehabilitation. The convalescent's return to the community would be aided if hospital and community services could be "so unified and blended as to largely lose their distinction in the minds of the staff, the patient and the community," in the opinion of Dr. Robert C. Hunt, assistant commissioner of the New York State Department of Mental Hygiene.

Several speakers emphasized that mental health is the proper concern of every aspect of community life.

Dr. Jules Henry, professor of anthropology at Washington University, proposed that "beginning at puberty our citizens begin to receive instruction in handling of each other's problems." Calling emotional suffering "a family epidemic," he said, "School children have been taught physical

hygiene; they can be taught to understand themselves and one another, which is mental hygiene, so that when they have families they will know what to do." Another speaker, Dr. Dana L. Farnsworth, held that mental health cannot be furthered in our schools if it is considered something apart from ordinary living. "It is the quality of learning, of teaching, of the sharing of experiences designed to further optimum growth," he said. "It must be in the thinking of all teachers and eventually all pupils." Dr. Farnsworth is director of Harvard University health services and professor of hygiene.

Harold P. Halpert, chief of publications and reports for the National Institute of Mental Health, pointed out that one of the basic difficulties in presenting mental health information is to present it in such a way that it changes attitudes and behavior. It is relatively simple, he said, to increase the average person's store of factual knowledge about mental health and mental illness but much less simple to increase his ability to apply his general concepts to himself and to others around him.

Summing up, Mr. Ryan told forum participants: "It is too early to have the kind of detached overview of what this forum means and may mean in progress toward better mental health. So much has been said that is significant and stimulating that it will take time and a less hectic atmosphere to develop the guidelines which may come from the forum.

"But looking back over the two days, these things stand out:

"1. Action must be community-centered and involve local professional and lay leadership.

"2. All health leaders, whether in governmental agencies, voluntary organizations, professional associations or private practice, have opportunities and responsibilities to work individually and together for better mental health.

"3. Patterns are becoming clear for the modification of professional training of health workers, in-service training, and career development and recruitment.

"4. There is no doubt as to the interdependence of all phases of community, national and world life in building better mental health."

PUBLICATIONS

As an aid to states in reviewing their mental health programs, the Interstate Clearing House on Mental Health has compiled 24 tables of figures on the finances, personnel and patients of public mental hospitals in the 48 states.

The report contains 5 tables on expenditures, 5 on patients, 5 on personnel and 9 on admissions and discharges. Some of the findings:

- Daily per capita maintenance expenditures are highest in Connecticut ($4.74), Kansas ($4.60), New Mexico ($4.35), Michigan ($4.33) and Delaware ($4.08), lowest in Tennessee ($1.84) and West Virginia ($1.90), with New York ($3.44), Wisconsin ($3.40) and Wyoming ($3.36) near the national average of $3.26.

- Last year readmissions made up 45.7% of all admissions to mental hospitals in Kentucky, 15.2% in Nevada, with the percentage of readmissions in all other states falling between these two.

- The best ratio of patients to personnel is in Kansas, which has one mental hospital employee for every two patients. The worst ratio is in Tennessee, where there is only one employee for every 6.2 patients. The

effort Kansas has made in recent years to increase the daily per capita expenditure from 70¢ in 1945 to $4.60 in 1956 and to attract mental hospital personnel seems to have paid off: In just five years between 1950 and 1954 the rate of discharges from Kansas mental hospitals increased from 107.8 (well below the national average of 148.5) to 181.4 (above the new average of 175.3).

Interpretation of such figures as these requires, however, a considerable degree of sophistication. For example, a state may show a high expenditure for the maintenance of each patient but fail to provide enough beds for all those in the state who should have care and treatment in a hospital. This discrepancy shows up when one calculates the average amount paid by each resident of the state for the care of the mentally ill and compares it with the amount paid by residents of states with populations of comparable size.

Overcrowding is also a factor, for on every overcrowded bed a state saves carrying charges on as much as $8,000 a year—at 4%, nearly $1.00 a day.

Another consideration is that some hospitals calculate the amount of their daily maintenance expenditure per patient by dividing their total budgets by the average daily census of patients—even if their budgets include the cost of out-patient clinics providing no service to in-patients. This makes the amount spent on each in-patient look like a good deal more than it actually is. In addition, in considering expenditures for services to out-patients one must bear in mind that some states provide subsidies for these services quite apart from the budgets for hospitalized patients. In fact, some have set up departments entirely separate from the hospitals to administer services to out-patients.

The figures on readmissions can mislead, too. Some readers may interpret a high rate of readmissions as a sign of failure. A high rate may, on the other hand, indicate an alertness by a hospital staff to the potentialities for discharge and a willingness to release patients experimentally.

Copies of the report are available from the Interstate Clearing House on Mental Health, Council of State Governments, 1313 E. 60th St., Chicago 37.

* * *

Admission policies and practices of child guidance clinics are discussed in a new U. S. Public Health Service publication, "Some Aspects of Child Guidance Clinic Intake Policy and Practices."

Such problems as referral of patients to clinics by other agencies, screening of patients and the relationship of clinics with other social agencies are discussed by the authors, Forrest N. Anderson, former director of the Los Angeles Child Guidance Clinic, and Helen C. Dean, child welfare specialist in the California State Department of Social Welfare.

The paper is based on a study of 500 cases treated in the Los Angeles clinic from 1948 to 1950. The authors emphasized suggestions for self-examination by clinics rather than specific recommendations for policies governing the admission of patients.

They point out the primary importance of a clinic's deciding whether its function is basically social or medical. On this decision should depend the clinic's policies on pre-screening patients before they are considered for admission and on accepting self-referred patients, those referred by physicians and those sent by other community agencies, normally the most serious cases.

The authors assert that 400 of the 500 cases studied could have been handled successfully by private physicians or other com-

munity agencies. They suggest that the clinic operate a consultation service for some of these agencies. In this way the clinic staff's influence and usefulness would be extended and the clinic could integrate itself more fully into the work of other community health and welfare agencies.

Since over 30% of the patients terminate treatment themselves against clinic advice, the authors suggest that the clinic somehow clarify its function and responsibility to patients or tighten admission requirements to exclude children whose parents are apparently "shopping around" for guidance service.

Single copies of the monograph are available from the public inquiries branch of the Public Health Service. As Public Health Publication No. 485 it is also sold by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., for 20¢ a copy.

* * *

The American Group Psychotherapy Association has announced the publication of a 44-page scientific abstract covering its 14th annual convention last January. To those interested in the field this comprehensive survey will have far-reaching value for years to come, according to Dr. Cornelius Beukenkamp, Jr., chairman of the public relations committee. The abstract is availagle for $1 from AGPA, Room 300, 345 E. 46th St., New York 17.

* * *

Noting the relatively recent active collaboration of sociologists and mental health specialists the American Sociological Society has published a 62-page bulletin setting forth "some of the present and potential contributions of social science to research and program operations in the mental health field." The author of *Sociology and the Field of Mental Health* is Dr. John A. Clausen, chief of the laboratory of socio-environmental studies in the National Institute of Mental Health. Copies are available from the Russell Sage Foundation, 505 Park Ave., New York 22, for 50¢ each.

* * *

The *Journal of Individual Psychology,* a publication of the American Society of Adlerian Psychology and formerly known as the *American Journal of Individual Psychology,* has broadened its editorial policy. The new policy presents the journal as the medium of expression of those in psychology and related fields who are interested in a holistic, teleological, phenomenological and socially oriented approach based on the assumptions of an active creative self, an open dynamic system of motivation and an innate potentiality for social living.

The journal invites theoretical and research papers, clinical and other practical contributions, informal notes and letters falling within this scope.

The May issue, the first under the new policy, contains papers by Hadley Cantril, Albert Ellis, Ruth Hartley, Clark Moustakas and Edmund Sinnott, among others, and a heretofore untranslated paper by Alfred Adler dated 1937, the year of his death.

Requests for sample copies and all other communications are to be addressed to the editor, Dr. H. L. Ansbacher, at the University of Vermont, Burlington.

* * *

The October 1956 number of the *NPPA Journal,* devoted to the problem of sentencing criminal offenders, contains two articles of interest to mental health specialists. One on the purpose of the sentence

stresses that with the passing years the emphasis in sentencing has shifted from avenging to protecting society, and points out that there is now the added aim of rehabilitating the offender.[1]

The other refers to the presentence investigation, probation's major operating instrument, as a "disciplined exploration of the offender's past history and future possibilities."[2] Originally meant as a guide to the court in estimating the degree of probation risk, the investigation has become the keystone of the diagnostic process and the modern investigation report the repository for all biographical data needed for supervising the probationer in the community or for planning and carrying out a rehabilitative program for the offender committed to a prison or reformatory.

Minimum standard practice calls for the report to provide information on the present offense and on co-defendants and accomplices, the defendant's statement, information on the attitude of the complainant, on aggravating and mitigating circumstances, on the defendant's prior criminal history, his antecedents, family background and development history, his living arrangements, religion, mental and physical health, character, habits and associations.

The author points out that the presentence investigation precludes blind gamble in placing offenders on probation, insures that those who do go to prison go there "as something more than numbers on a shirt or cards in a file" and puts the prison administration in a position "to get out of each individual whatever creative values are there to get."

---

[1] Ira W. Jayne, "The Purpose of the Sentence," *NPPA Journal*, 2(1956), 315–19.

[2] Edmund Fitzgerald, "The Presentence Investigation," *ibid.*, 320–36.

Volume I, Number 1 of the *APTO Journal* appeared in February. It is the organ of the Association for Psychiatric Treatment of Offenders, a membership organization whose purpose is the advancement of scientific concepts in the handling and treatment of adult and youthful offenders.

The new journal of opinion will appear bi-monthly and will feature articles only 400 to 600 words long on facts of crime, delinquency and scientific methods of dealing with criminal behavior. "We are losing the fight against crime," writes Dr. Melitta Schmideberg, co-editor," and we want to know why. We want the opinions of informed responsible persons why all our measures are not being effective."

* * *

Organizations serving veterans and their families will find useful the 1957 edition of the *Handbook of Federal Benefits for Veterans.* It provides up-to-date explanations of more than 40 benefits available from the Veterans Administration. The 90-page handbook is available from the Social Legislation Information Service, 1346 Connecticut Ave., N. W., Washington 6, D. C., for $1.50 a copy.

There are now over 22,000,000 veterans eligible for a great variety of health, education, social welfare and other government benefits and services—at an annual cost of almost $5,000,000,000.

* * *

Teachers, librarians, clergymen, guidance and personnel workers—all those to whom young people and adults turn with questions on educational and vocational plans —will find the *1956 Directory of Counseling Agencies* a valuable resource. The directory

lists 143 agencies, located in all parts of the country, offering testing and counseling services that help in making wise vocational and educational decisions.

Referrals can be made to these agencies with confidence. Each has been examined and approved by the American Personnel and Guidance Association's committee on professional practices.

Each agency has met the APGA's minimum standards: recognition by appropriate professional groups or qualified members of such groups, use of competent and qualified staff, adherence to accepted professional procedures, avoidance of questionable commercial publicity or advertising, and the charging of reasonable fees.

The directory is available from the American Personnel and Guidance Association, 1534 O St., N. W., Washington 5, D. C., for $1.00 a copy.

* * *

Mental and neurological diseases may account for more days of disability in younger age groups than any other kind of illness. They continue as the leading cause of days of disability until old age.

These are among the statistical interpretations of *Health and Demography*, a report by Dr. Halbert L. Dunn, chief of the National Office of Vital Statistics.

Several of his many demographic findings, all with mental health implications, dramatically point up the increasing frequency of mental and neurological diseases. Analysis of the 12 diagnoses with the highest annual rates per 1,000 population in each of three younger age-groups for annual days of disability and annual days confined to bed reveals:

- Mental and neurological diseases rank 3rd for days of disability among children under 5 (outranked only by whooping cough and bronchitis).
- Mental and neurological diseases rank 1st for both days of disability and days in bed among children between 5 and 14 and between 15 and 24, topping even all accidents.

These diseases remain as the leading cause of disability and days in bed for adults from 25 through 64 also.

The 94-page report, published in 1956, is available from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., for 50¢ a copy.

* * *

Must the superintendent of a mental hospital be a physician-psychiatrist?

Dr. Addison M. Duval, assistant superintendent of St. Elizabeths Hospital, Washington, D. C., argues that a mental hospital superintendent must be a physician with training and experience in hospital psychiatry and if possible in scientific management. Noting that the question of utilizing lay superintendents in mental hospitals has been raised with increasing frequency, Dr. Duval comments that "aggressive action on this question by any organized group could threaten the very foundations of mental hospital functioning as it has developed in America."

Taking another view, Robert H. Klein, board member of Michael Reese Hospital in Chicago, and Dr. Paul E. Feldman, director of research and education at the Topeka State Hospital, assert that men who are not psychiatrists can be trained in the special and more technical aspects of mental hospital administration. The chief qualification, they say, should be administrative ability.

"In choosing a mental hospital superintendent, our preference would be, of course, a psychiatrist who is a good admin-

istrator," they acknowledge. "But lacking a person with both qualifications, we would choose a good administrator rather than a psychiatrist lacking administrative ability."

They maintain that graduate training in psychiatry "is usually accomplished without ever obtaining any theoretical or practical experience in business administration." They point to a 1953 survey conducted by the American Hospital Association which showed that mental and allied governmental hospital administrators spent only 47% of their time on administrative matters. More than one-half of their time was spent on other activities of which direct medical care represented the biggest segment.

Citing the same survey, the authors compare this figure with the 90% indicative of the time administrators of short-term hospitals with 250 beds or more spend on administrative duties. They maintain that administration of a large mental hospital must suffer if the administrator spends most of his time in clinical practice.

Dr. Duval holds that the administrator of a mental hospital is so intimately a part of the therapeutic program that a physician superintendent is mandatory.

He says, "The history of the development of mental hospitals in America is largely the history of the accomplishments of the physicians who were the superintendents of these hospitals." He maintains that those mental hospitals which are today recognized as the best in the country are all administered by physicians. He visualizes today's mental hospital as a "therapeutic community" where every function and action is designed to meet the treatment needs of the patient. Only a physician can assume this broadly based therapeutic responsibility, he asserts.

"Special preparation for the mental hospital administrator must be developed," admits Dr. Duval. Scientific management courses "might well be required for future physician superintendents of mental hospitals," he says. But he points out that the physician superintendents' primary duty is to control the function and give leadership to all hospital employees so that the best treatment and care of the patients will be assured. The details concerning treatment and administration, says Dr. Duval, are the responsibility of his assistants and should be so delegated.

Mr. Klein and Dr. Feldman argue that there are aspects of psychiatry that the psychiatrist has to unlearn when he assumes the role of a medical administrator, for one thing that there is a basic difference between the administrative and the psychiatric approach to people. Administrative thinking is group-centered rather than individual-centered. The psychiatrist is more inclined to isolate the individual from the group and act towards the individual without considering the effect of his action on the total group.

"The psychiatrist, being trained to think in terms of personality pathology, may reduce his administrative effectiveness because he does not restrain his tendency to search for personality defects in his employees—even when they are performing satisfactorily on the job."

They note the scarcity of psychiatrists from whom mental hospital superintendents may be drawn and conversely the large number of lay administrators who, properly trained, can assume the supervision of a mental hospital.

The conflicting points of view were aired in the January 16 issue of *Hospitals*, journal of the American Hospital Association.

INTERSTATE COMPACT ON MENTAL HEALTH

The problem of caring for non-resident mental patients has plagued state mental health administrators for many a long year. Frequently they find themselves caught between humanitarian considerations on the one hand and restrictive residence requirements on the other. As a result, they often must steer their course by what the law requires rather than by what the individual patient needs.

Considering the number of transfers in and out of a state and the high cost of moving mental patients, it is doubtful if penny-pinching residence requirements have ever accomplished anything more than to deny prompt care to thousands of patients. That is extravagance, not economy.

In the last 18 months, however, the states have found a solution to this problem—the Interstate Compact on Mental Health. It is already part of the legal machinery of four states—Connecticut (1955), New York and Massachusetts (1956) and New Jersey (1957)—and is currently before the legislatures of Missouri, New Hampshire and Rhode Island.

The compact has four main purposes:

- To assure that any state signing the compact will give care and treatment to any person found in that state who is in need of hospitalization because of mental illness or mental deficiency.

- To permit the transfer of that patient to an institution in another state when clinical considerations indicate that transfer is in the best interests of the patient.

- To provide cooperative interstate machinery for after-care or supervision of convalescing patients conditionally released from mental institutions.

- To authorize additional supplementary agreements between states "for the provision of any service or facility or for the maintenance of any institution on a joint or cooperative basis" when any two or more states wish to make them.

With the ratification of the compact by all state legislatures, residence requirements will give way to what is best for the patient.

The final perfected draft as approved September 30, 1955 reads as follows:

The contracting states solemnly agree that:

Article I

The party states find that the proper and expeditious treatment of the mentally ill and mentally deficient can be facilitated by cooperative action, to the benefit of the patients, their families and society as a whole. Further, the party states find that the necessity of and desirability for furnishing such care and treatment bear no primary relation to the residence or citizenship of the patient but that, on the contrary, the controlling factors of community safety and humanitarianism require that facilities and services be made available for all who are in need of them. Consequently, it is the purpose of this compact and of the party states to provide the necessary legal basis for the institutionalization or other appropriate care and treatment of the mentally ill and mentally deficient under a system that recognizes the paramount importance of patient welfare and to establish the responsibilities of the party states in terms of such welfare.

Article II

As used in this compact:

(a) "Sending state" shall mean a party state from which a patient is transported pursu-

ant to the provisions of the compact or from which it is contemplated that a patient may be so sent.

(b) "Receiving state" shall mean a party state to which a patient is transported pursuant to the provisions of the compact or to which it is contemplated that a patient may may be so sent.

(c) "Institution" shall mean any hospital or other facility maintained by a party state or political subdivision thereof for the care and treatment of mental illness or mental deficiency.

(d) "Patient" shall mean any person subject to or eligible as determined by the laws of the sending state, for institutionalization or other care, treatment or supervision pursuant to the provisions of this compact.

(e) "After-care" shall mean care, treatment and services provided a patient, as defined herein, on convalescent status or conditional release.

(f) "Mental illness" shall mean mental disease to such extent that a person so afflicted requires care and treatment for his own welfare or the welfare of others or of the community.

(g) "Mental deficiency" shall mean mental deficiency as defined by appropriate clinical authorities to such extent that a person so afflicted is incapable of managing himself and his affairs, but shall not include mental illness as defined herein.

(h) "State" shall mean any state, territory or possession of the United States, the District of Columbia and the Commonwealth of Puerto Rico.

Article III

(a) Whenever a person physically present in any party state shall be in need of institutionalization by reason of mental illness or mental deficiency, he shall be eligible for care and treatment in an institution in that state irrespective of his residence, settlement or citizenship qualifications.

(b) The provisions of paragraph (a) of this article to the contrary notwithstanding, any patient may be transferred to an institution in another state whenever there are factors based upon clinical determinations indicating that the care and treatment of said patient would be facilitated or improved thereby. Any such institutionalization may be for the entire period of care and treatment or for any portion or portions thereof. The factors referred to in this paragraph shall include the patient's full record with due regard for the location of the patient's family, character of the illness and probable duration thereof, and such other factors as shall be considered appropriate.

(c) No state shall be obliged to receive any patient pursuant to the provisions of paragraph (b) of this article unless the sending state has given advance notice of its intention to send the patient; furnished all available medical and other pertinent records concerning the patient; given the qualified medical or other appropriate clinical authorities of the receiving state an opportunity to examine the patient if said authorities so wish; and unless the receiving state shall agree to accept the patient.

(d) In the event that the laws of the receiving state establish a system of priorities for the admission of patients, an interstate patient under this compact shall receive the same priority as a local patient and shall be taken in the same order and at the same time that he would be taken if he were a local patient.

(e) Pursuant to this compact, the determination as to the suitable place of institutionalization for a patient may be reviewed at

any time and such further transfer of the patient may be made as seems likely to be in the best interest of the patient.

Article IV

(a) Whenever, pursuant to the laws of the state in which a patient is physically present, it shall be determined that the patient should receive after-care or supervision, such care or supervision may be provided in a receiving state. If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state shall have reason to believe that after-care in another state would be in the best interest of the patient and would not jeopardize the public safety, they shall request the appropriate authorities in the receiving state to investigate the desirability of affording the patient such after-care in said receiving state, and such investigation shall be made with all reasonable speed. The request for investigation shall be accompanied by complete information concerning the patient's intended place of residence and the identity of the person in whose charge it is proposed to place the patient, the complete medical history of the patient and such other documents as may be pertinent.

(b) If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state and the appropriate authorities in the receiving state find that the best interest of the patient would be served thereby, and if the public safety would not be jeopardized thereby, the patient may receive after-care or supervision in the receiving state.

(c) In supervising, treating or caring for a patient on after-care pursuant to the terms of this article, a receiving state shall employ the same standards of visitation, examination, care and treatment that it employs for similar local patients.

Article V

Whenever a dangerous or potentially dangerous patient escapes from an institution in any party state, that state shall promptly notify all appropriate authorities within and without the jurisdiction of the escape in a manner reasonably calculated to facilitate the speedy apprehension of the escapee. Immediately upon the apprehension and identification of any such dangerous or potentially dangerous patient, he shall be detained in the state where found pending disposition in accordance with law.

Article VI

The duly accredited officers of any state party to this compact, upon the establishment of their authority and the identity of the patient, shall be permitted to transport any patient being moved pursuant to this compact through any and all states party to this compact, without interference.

Article VII

(a) No person shall be deemed a patient of more than one institution at any given time. Completion of transfer of any patient to an institution in a receiving state shall have the effect of making the person a patient of the institution in the receiving state.

(b) The sending state shall pay all costs of and incidental to the transportation of any patient pursuant to this compact, but any two or more party states may, by making a specific agreement for that purpose, arrange for a different allocation of costs as among themselves.

(c) No provision of this compact shall be construed to alter or affect any internal relationships among the departments, agencies and officers of and in the government of

a party state, or between a party state and its subdivisions, as to the payment of costs or responsibilities therefor.

(d) Nothing in this compact shall be construed to prevent any party state or subdivision thereof from asserting any right against any person, agency or other entity in regard to costs for which such party state or subdivision thereof may be responsible pursuant to any provision of this compact.

(e) Nothing in this compact shall be construed to invalidate any reciprocal agreement between a party state and a non-party state relating to institutionalization, care or treatment of the mentally ill or mentally deficient, or any statutory authority pursuant to which such agreements may be made.

Article VIII

(a) Nothing in this compact shall be construed to abridge, diminsh or in any way impair the rights, duties and responsibilities of any patient's guardian on his own behalf or in respect of any patient for whom he may serve, except that where the transfer of any patient to another jurisdiction makes advisable the appointment of a supplemental or substitute guardian, any court of competent jurisdiction in the receiving state may make such supplemental or substitute appointment and the court which appointed the previous guardian shall upon being duly advised of the new appointment, and upon the satisfactory completion of such accounting and other acts as such court may by law require, relieve the previous guardian of power and responsibility to whatever extent shall be appropriate in the circumstances; provided, however, that in the case of any patient having settlement in the sending state, the court of competent jurisdiction in the sending state shall have the sole discretion to relieve a guardian appointed by it or continue his power and responsibility, whichever it shall deem advisable. The court in the receiving state may, in its discretion, confirm or reappoint the person or persons previously serving as guardian in the sending state in lieu of making a supplemental or substitute appointment.

(b) The term "guardian" as used in paragraph (a) of this article shall include any guardian, trustee, legal committee, conservator or other person or agency however denominated who is charged by law with power to act for or responsibility for the person or property of a patient.

Article IX

(a) No provision of this compact except Article V shall apply to any person institutionalized while under sentence in a penal or correctional institution or while subject to trial on a criminal charge, or whose institutionalization is due to the commission of an offense for which, in the absence of mental illness or mental deficiency, said person would be subject to incarceration in a penal or correctional institution.

(b) To every extent possible it shall be the policy of states party to this compact that no patient shall be placed or detained in any prison, jail or lockup, but such patient shall, with all expedition, be taken to a suitable institutional facility for mental illness or mental deficiency.

Article X

(a) Each party state shall appoint a "compact administrator" who, on behalf of his state, shall act as general coordinator of activities under the compact in his state and who shall receive copies of all reports, correspondence and other documents relating to any patient processed under the compact

by his state either in the capacity of sending or receiving state. The compact administrator or his duly designated representative shall be the official with whom other party states shall deal in any matter relating to the compact or any patient processed thereunder.

(b) The compact administrators of the respective party states shall have power to promulgate reasonable rules and regulations to carry out more effectively the terms and provisions of this compact.

Article XI

The duly constituted administrative authorities of any two or more party states may enter into supplementary agreements for the provision of any service or facility or for the maintenance of any institution on a joint or cooperative basis whenever the states concerned shall find that such agreements will improve services, facilities or institutional care and treatment in the fields of mental illness or mental deficiency. No such supplementary agreement shall be construed so as to relieve any party state of any obligation which it otherwise would have under other provisions of this compact.

Article XII

This compact shall enter into full force and effect as to any state when enacted by it into law and such state shall thereafter be a party thereto with any and all states legally joining therein.

Article XIII

(a) A state party to this compact may withdraw therefrom by enacting a statute repealing the same. Such withdrawal shall take effect one year after notice thereof has been communicated officially and in writing to the governors and compact administrators of all other party states. However, the withdrawal of any state shall not change the status of any patient who has been sent to said state or sent out of said state pursuant to the provisions of the compact.

(b) Withdrawal from any agreement permitted by Article VII (b) as to costs or from any supplementary agreement made pursuant to Article XI shall be in accordance with the terms of such agreement.

Article XIV

This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstances shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

POSTSCRIPT

Influences more practical than editorial caprice dictated the new look of MENTAL HYGIENE. The 2-column page, more readable than the former page, also offers 46% more matter. Result: more papers and a shorter interval between acceptance and publication. We greatly appreciate your patience with delayed issues while the new look was aborning . . . you may expect to receive future issues promptly.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a coordinated citizens organization working toward the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.
